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Project Year Two, 2013

ANNUAL REPORT

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Lembaga Kesehatan Budi Kemuliaan

Save the Children

RTI INTERNATIONAL

TABLE OF CONTENTS

I. INTRODUCTION

The USAID/Indonesia Expanding Maternal and Neonatal Survival (EMAS) Project is a five year program to support the Government of Indonesia to reduce maternal and newborn mortality. EMAS works with Indonesian government agencies (national, provincial and local), Civil Society Organizations, public and private health facilities, hospital associations, professional organizations, and the private sector. The project is expected to contribute to an overall 25% decline in national maternal and newborn mortality, and it is focusing on two major objectives:

1. Improving the quality of emergency obstetric and neonatal care services in hospitals and community health centers; and
2. Increasing the efficiency and effectiveness of referral systems between community health centers and hospitals.

Over the course of five years, EMAS will work with at least 150 hospitals (both public and private) and 300 community health centers across 30 districts and cities in six provinces—North Sumatra, Banten, West Java, Central Java, East Java, and South Sulawesi. EMAS will also emphasize scale up and sustainability in order to impact districts and provinces outside of the EMAS target districts.

Year Two marked the first full year of implementation for EMAS. Data and results discussed in subsequent sections show steady progress across nearly all program intervention areas. Intensive efforts throughout the year focused on developing strong health facilities capable of taking on a mentoring role in Phase 2 have been successful. In total 16 hospitals and 33 puskesmas are expected to take on a mentoring role in Year Three (Figure 1). With the experience from one year of implementation as well as the need to plan for Phase 2 expansion, Year Two presented EMAS with an opportunity to assess strengths, make course corrections and refine strategies for the future. This report describes the progress made towards EMAS objectives during Year Two, refinements to strategies and approaches made during the year and presents a detailed review of progress made in implementing key activities.

III. EMAS STRATEGIC APPROACH

EMAS program roll out is staggered in a series of phases: Phase 1 (Program Years 1-2), Phase 2 (Program Year 3) and Phase 3 (Program Years 4-5). With each new phase, EMAS is presented with an opportunity to assess progress and learning to date to inform implementation and strategies for subsequent phases. Using experience from Phase 1 roll out, in Program Year 2, EMAS focused on refining its expansion approach, strategic framework, and PMP. EMAS was fortunate to also receive a visit from Dr Allisyn Moran from USAID Washington, who aided in the process making recommendations to refine EMAS's strategic approaches, guiding frameworks and strategic documents.

Expansion Approach

In Phase 1, EMAS implemented activities in ten districts, including 25 hospitals[1] and 93 puskesmas. Near the middle of Year 2, EMAS began preparing for Phase 2 expansion, which will add an approximate 55 hospitals and 100 puskesmas beginning in Year 3. As opposed to Phase 1, where EMAS only worked in districts, EMAS (with USAID) decided to add cities to its target geographic areas to increase program impact. The new approach enables EMAS to work in major referral hospitals as well as in cities where vertical, provincial or influential Muhammadiyah hospitals are located.

[1] This number includes the 23 Phase 1 hospitals across 10 districts and 2 Muhammadiyah hospitals located in Jakarta

Figure 1: EMAS Year 3 Vanguard Hospitals and Puskesmas

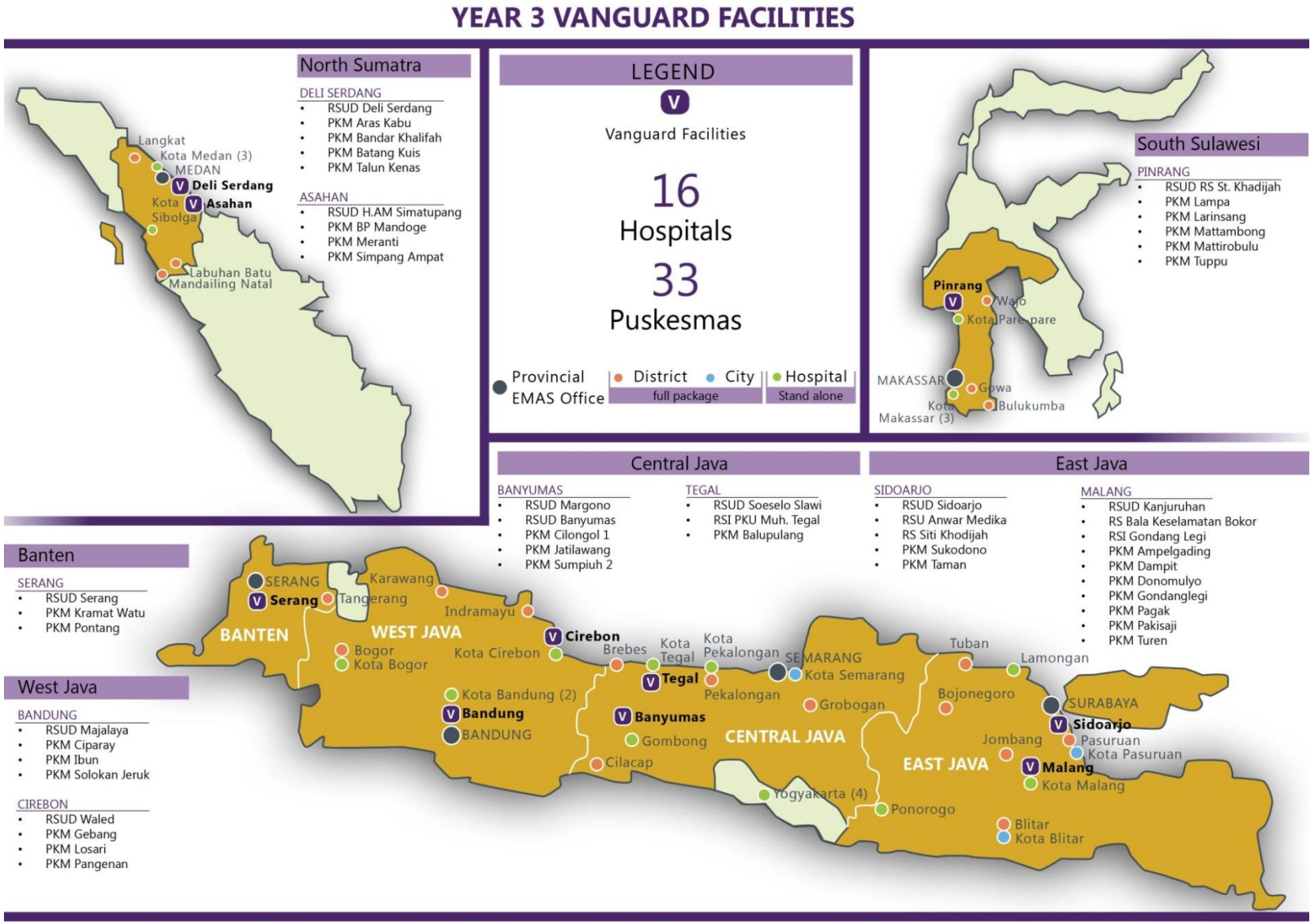
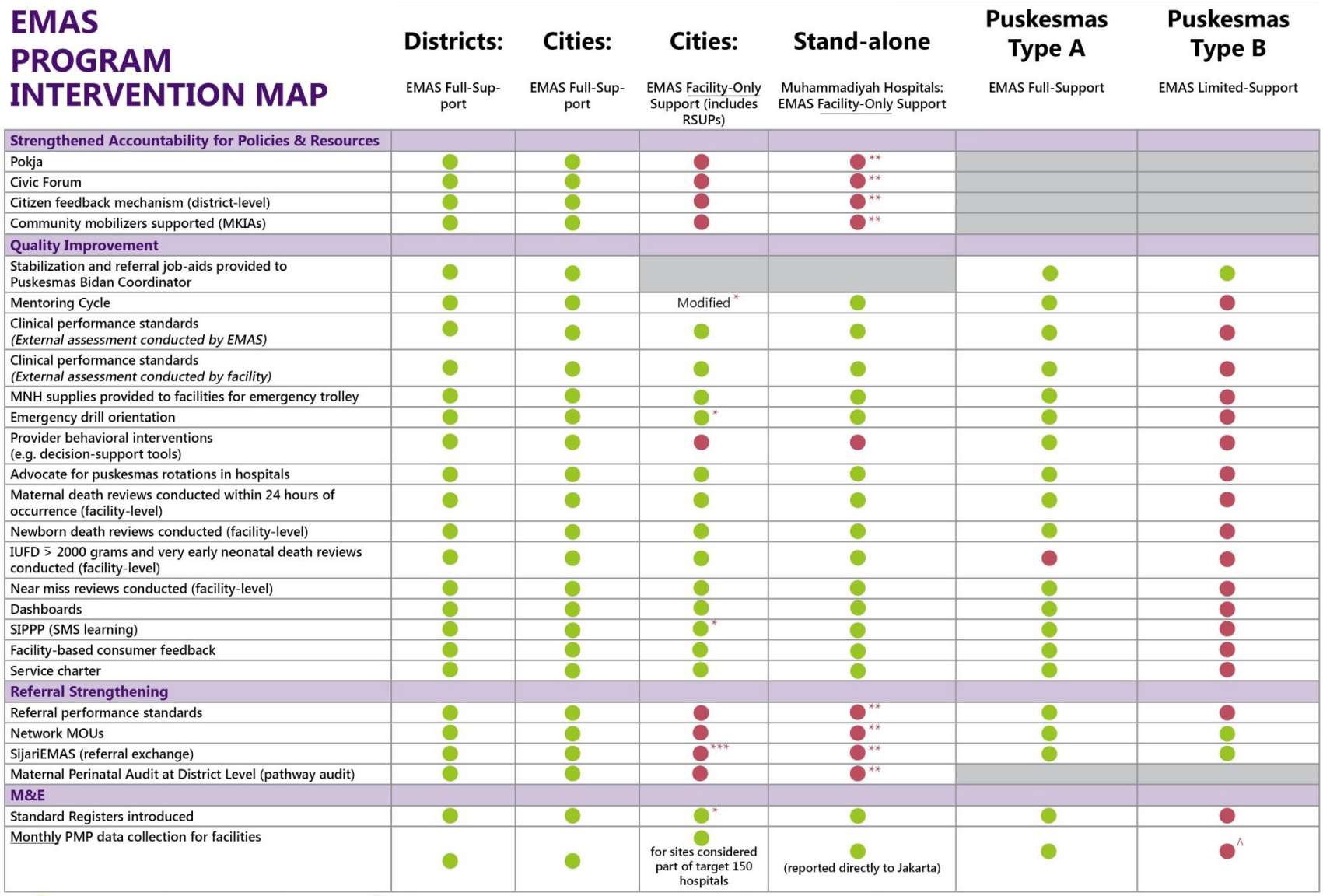


Figure 2: EMAS Intervention Map



EMAS PROGRAM INTERVENTION MAP	Districts: EMAS Full-Support	Cities: EMAS Full-Support	Cities: EMAS Facility-Only Support (includes RSUPs)	Stand-alone Muhammadiyah Hospitals: EMAS Facility-Only Support	Puskesmas Type A EMAS Full-Support	Puskesmas Type B EMAS Limited-Support
Strengthened Accountability for Policies & Resources						
Pokja	●	●	●	●**		
Civic Forum	●	●	●	●**		
Citizen feedback mechanism (district-level)	●	●	●	●**		
Community mobilizers supported (MKIAs)	●	●	●	●**		
Quality Improvement						
Stabilization and referral job-aids provided to Puskesmas Bidan Coordinator	●	●			●	●
Mentoring Cycle	●	●	Modified *	●	●	●
Clinical performance standards *(External assessment conducted by EMAS)*	●	●	●	●	●	●
Clinical performance standards *(External assessment conducted by facility)*	●	●	●	●	●	●
MNH supplies provided to facilities for emergency trolley	●	●	●	●	●	●
Emergency drill orientation	●	●	●*	●	●	●
Provider behavioral interventions (e.g. decision-support tools)	●	●	●	●	●	●
Advocate for puskesmas rotations in hospitals	●	●	●	●	●	●
Maternal death reviews conducted within 24 hours of occurrence (facility-level)	●	●	●	●	●	●
Newborn death reviews conducted (facility-level)	●	●	●	●	●	●
IUFD ≥ 2000 grams and very early neonatal death reviews conducted (facility-level)	●	●	●	●	●	●
Near miss reviews conducted (facility-level)	●	●	●	●	●	●
Dashboards	●	●	●	●	●	●
SIPPP (SMS learning)	●	●	●*	●	●	●
Facility-based consumer feedback	●	●	●	●	●	●
Service charter	●	●	●	●	●	●
Referral Strengthening						
Referral performance standards	●	●	●	●**	●	●
Network MOUs	●	●	●	●**	●	●
SijariEMAS (referral exchange)	●	●	●***	●**	●	●
Maternal Perinatal Audit at District Level (pathway audit)	●	●	●	●**		
M&E						
Standard Registers introduced	●	●	●*	●	●	●
Monthly PMP data collection for facilities	●	●	● for sites considered part of target 150 hospitals	● (reported directly to Jakarta)	●	●^

Sign ● indicate that particular intervention is implemented; Sign ● indicate a particular intervention is not implemented. Asteriks (**) are used to indicate where exceptions may be granted after approval by EMAS COP.

* Quality improvements interventions targeting RSUPs will be based on needs identified by the Component 1 Team; registers will be introduced, as needed

** Select stand-alone Muhammadiyah hospitals may work with pokjas and implement referral interventions, (e.g. SijariEMAS) on a case-by-case basis in consultation with the EMAS COP based on performance and resource considerations. Muhammadiyah hospitals located within an EMAS district will implement the full package of EMAS interventions, including all referral interventions.

*** In the case were an RSUP is the referral end point for RSUDs in an EMAS full support district or city, the RSUP should be included within SijariEMAS.

^ Fo Puskesmas type B, SijariEMAS will provide data on the number of referred cases and on the complications associated with those cases.

EMAS selected Phase 2 districts/cities based on a set of criteria which sought to quantify various elements believed to lead to strong performance, while balancing important factors such as high case-load within the facility and referral network, commitment and interest to participate in the program, and potential influence beyond the district. Mid-year, EMAS collected and analyzed selection criteria data, met with provincial health offices and candidate districts and cities and towards the end of the year, was able to finalize the list of Phase 2 EMAS sites in collaboration with USAID.

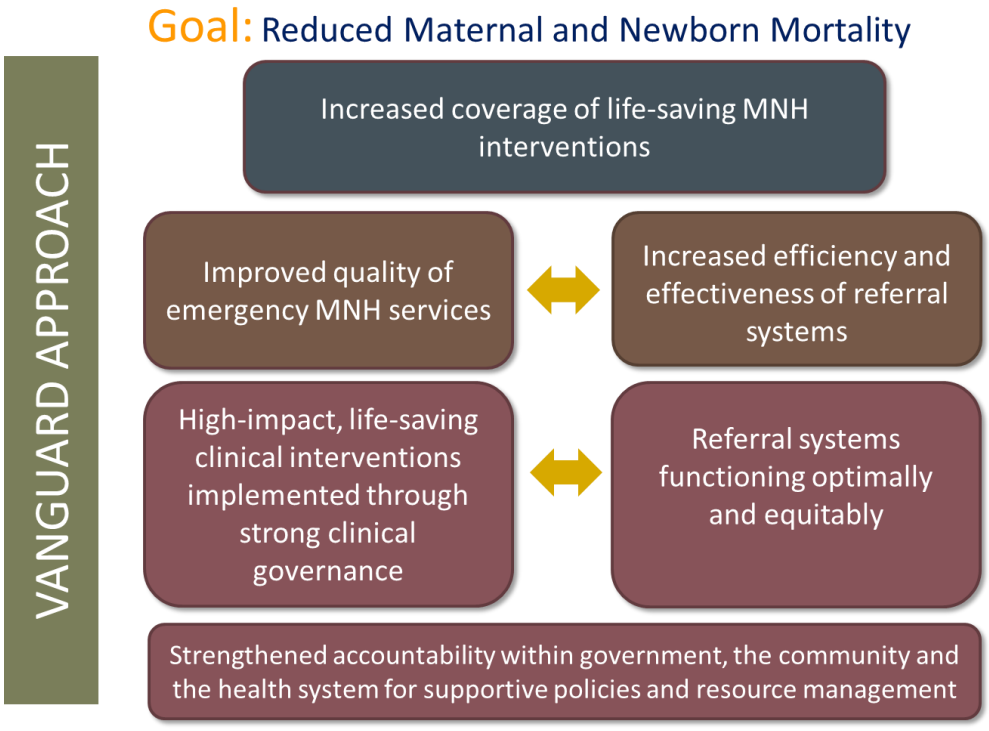
Depending on the location and rationale behind choosing a site location, EMAS interventions will be tailored accordingly in Phase 2. In Year Two, EMAS developed the Program Intervention Map (Figure 2) to define the scope of EMAS interventions in Phase 2 target areas and facilities.

In Year 2, EMAS also developed standardized guidelines to ensure consistency across the various program components. EMAS developed guidelines for key EMAS interventions and activities in both quality improvement and referral components. A list of the guidelines is available in Annex 4.

Updates to EMAS PMP and Strategic Framework

In Year 2, EMAS revised its strategic framework to better align with program components and priorities. A notable change to the strategic framework, Figure 3 below, was the division of Component 2 interventions into two distinct objectives.

Figure 3: EMAS Strategic Framework, Revised



The EMAS PMP was subsequently revised in the middle of Year Two to align with the revised strategic framework. USAID also provided recommendations for additional revisions to the EMAS PMP, with the primary goal of including indicators representative of the full EMAS program. The original PMP included a disproportionate number of indicators focused on clinical outcomes, and revisions made in Year Two aim to assess progress and results across the full range of EMAS intervention areas. EMAS expects to begin reporting against the revised PMP in Year Three, once it has been approved by USAID.

III. DISCUSSION OF YEAR 2 RESULTS

Year Two results show improvements in nearly all measures across the program compared to the Baseline assessment. While it is early to draw conclusions regarding the impact of EMAS interventions, trends show overall movement in the right direction in both maternal and newborn indicators. Similarly, analyses of the relationship between EMAS interventions (such as performance standards) and relevant measures of service quality in Year Two generally show a positive correlation. A discussion of Year Two results is provided below. Data and charts included in this report show comparison of Baseline, Year One and Year Two data, where possible. EMAS interventions in facilities and referral systems began in the last quarter of Year One (July – September 2012), thus Year One data is only inclusive of Quarter 4. In cases where Baseline and/or Year One data are not available, progress is shown across Quarters 1 through 4 in Year Two.

Overall, there has been an increase in the number of deliveries and live births in EMAS facilities in Year Two compared to Baseline (Table 1). Across all EMAS facilities this year, there was 163 maternal deaths, 640 newborn deaths (> 2000 grams), and 578 intra-partum deaths (>2000 grams).

Table 1: EMAS Facility Delivery and Mortality Data, Baseline vs. Year Two (N=23 Hospitals, 93 Puskesmas)

	Baseline (2011)	Year Two
Number of deliveries	46,401	51,069
Number of live births > 2000 grams	38,810	47,661
Number of intra-partum deaths (fresh still births) > 2000 grams	653	578
Number of newborn deaths > 2000 grams	526	640
Total number of maternal deaths (all facilities)	128	163

Maternal Survival Interventions

Insignificant changes were seen from Baseline to Year Two in relation to the cause of maternal mortality in EMAS facilities (Figure 4). Deaths associated with pre-eclampsia/eclampsia remained the number one cause of death in facilities, followed by deaths associated with postpartum hemorrhage. Deaths associated with infection remained the lowest. Nearly half of all maternal deaths are associated with other causes, a proportion that gradually increased over the year. In Year Three EMAS will include other categories of maternal complications in facility data collection to gain a better understanding of complications associated with maternal deaths.

Improvements were seen across nearly all maternal-related service statistics in Year Two compared to baseline (Figure 5). While the percent of women who received at least one dose of uterotonic postpartum during the third stage of labor was already quite high at Baseline- 82 percent - data from Quarter 4 shows a 12 point jump, to 94 percent. As the use of uterotonic has increased, EMAS has also seen a steady decrease in the percentage of women with postpartum hemorrhage (Figure 6). At Baseline, 2.1 percent of women had postpartum hemorrhage (PPH), with rates decreasing to 1 percent of deliveries by the end of Quarter 4. While this represents a small percentage change, the actual number of PPH cases went from a high of 174 among 8675 cases in the first quarter of the year to a low of 99 among 10,359 cases by the end of Quarter 4. During this same time period, as shown in Figure 4, the percentage of maternal deaths in EMAS facilities associated with PPH also decreased.

Progress in increasing the percent of women who were treated with magnesium sulfate for eclampsia/pre-eclampsia cases before referral remained slow throughout the year, but increased to 32 percent by the end of Quarter 4 (Figure 5). Although the average percentage (86 percent) of cases treated with magnesium sulfate for severe eclampsia/pre-eclampsia for Year Two shows overall progress compared to Baseline, Quarter 4 showed little movement in this area.

Figure 4: Complications associated with maternal mortality in EMAS hospitals, Baseline vs. Year Two, Quarter 4 (n=23)

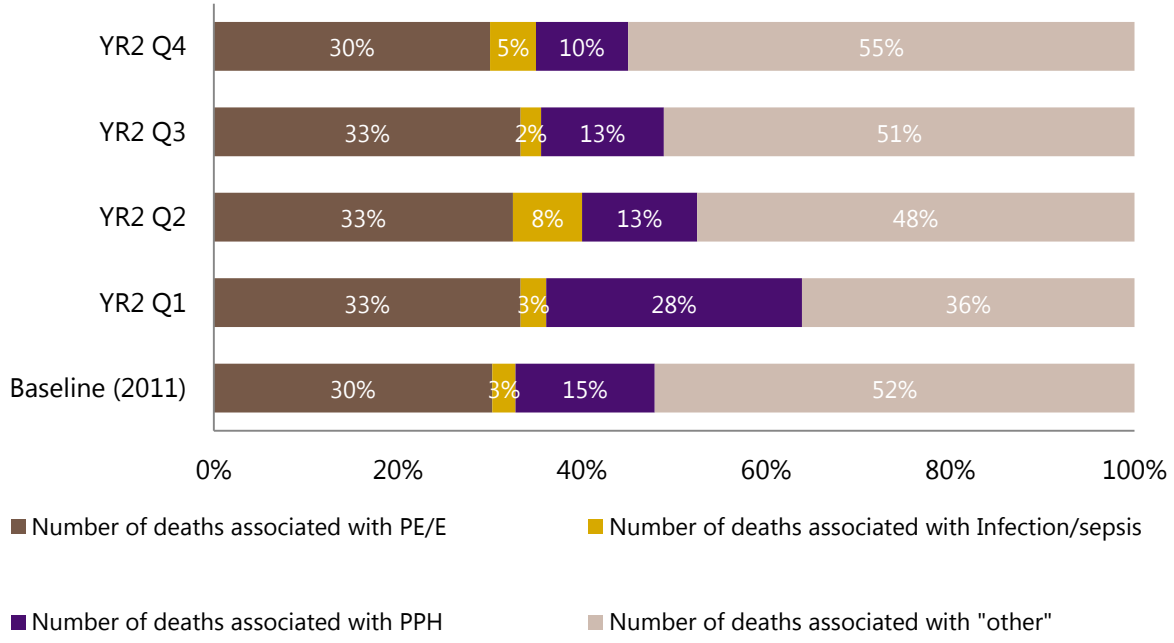
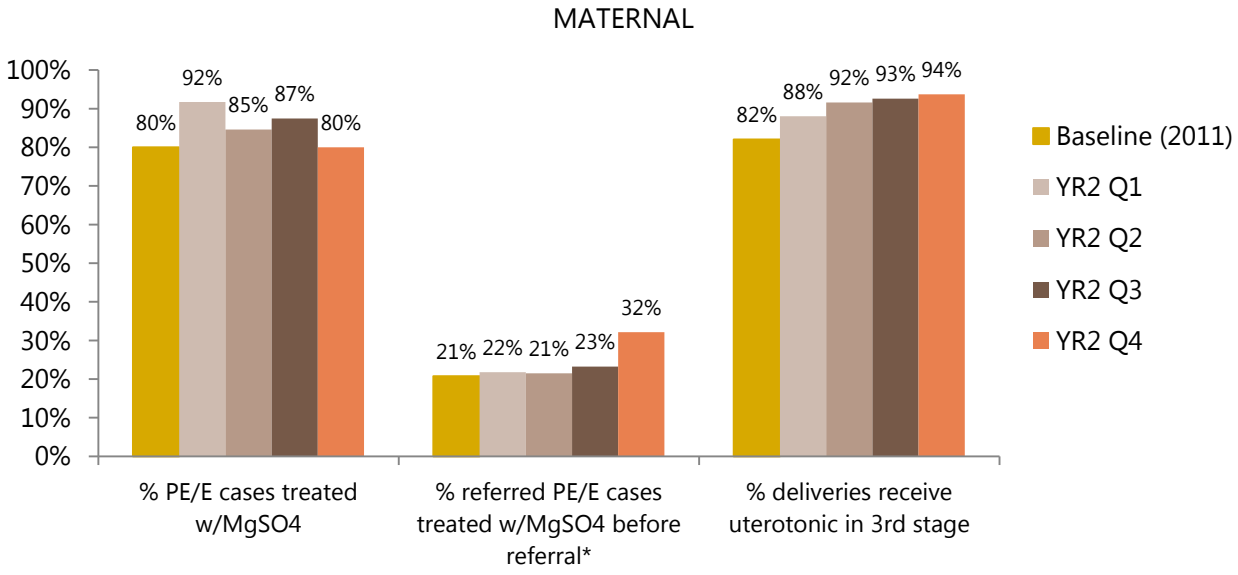
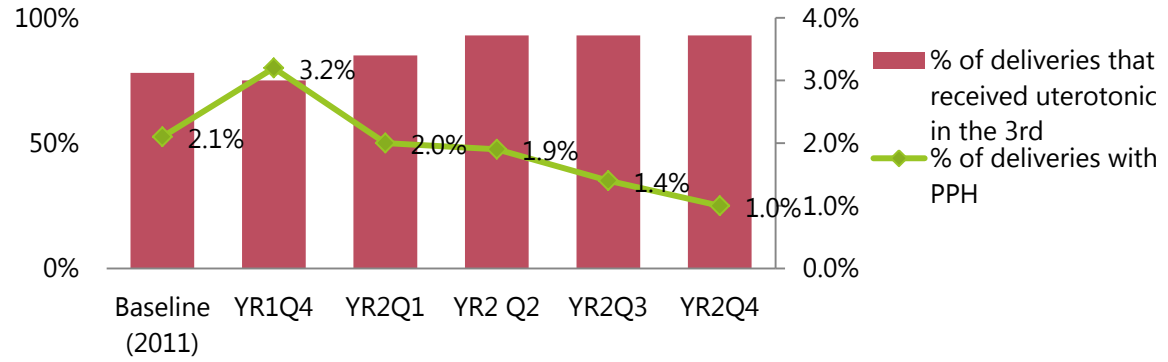


Figure 5: EMAS facility service statistics, Maternal, Baseline vs. Year Two (N=23 Hospitals, 93 Pkms)



*Data from hospitals only

Figure 6: % of deliveries with PPH compared to % of women who received uterotonic in 3rd stage of labor, EMAS Hospitals (N=23)*



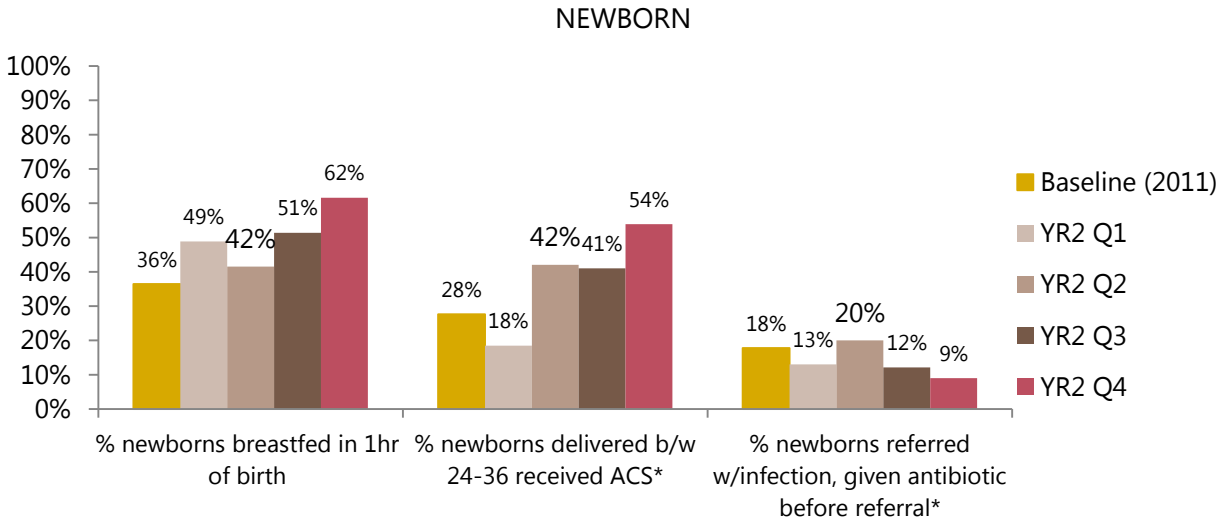
* Prior to Year Two Quarter 2, data quality for uterotonic was of concern as data were typically available in primary records (partographs) and as a result were not collected or reported in a standardized manner.

Given that pre-eclampsia/eclampsia is the most common cause of death in the target facilities, it is essential moving forward that a higher percentage of women receive MgSO4 prior to referral. To date, EMAS has directly targeted a portion of the puskesmas (approximately 20%) in each district. In Phase 2, EMAS will work with **all** puskesmas and private midwife practices on stabilization and referral.

Newborn Survival Interventions

Clinical interventions to improve newborn outcomes showed strong improvements in Year Two compared to Baseline, except in the percentage of newborns with infection given antibiotics before referral (Figure 7). Increases in the percentage of newborns born between 24 and 36 weeks who received antenatal corticosteroids (ACS) increased from 28 percent at Baseline to 54 percent by the end of Quarter 4 (Figure 7). Increases in the percentages of premature newborns who received ACS are positively correlated to the achievement of hospital performance standards related to antenatal corticosteroids (Figure 8). Similar trends are seen in breastfeeding measures. The overall percentage of newborns who are breastfed within one hour of birth has increased over Baseline (36 percent) to 62 percent at the end of Quarter 4 (Figure 7). Similar to ACS, increases in the percentage of newborns breastfed within one hour corresponds to the achievement of hospital performance standards related to breastfeeding (Figure 9)

Figure 7: EMAS facility service statistics, newborn, Baseline vs. Year Two (N=23 Hospitals, 93 Pkms)



*Data from hospitals only

Figure 8: Percentage of preterm deliveries provided ACS in comparison to hospital achievement on related performance standard (Neonatal, Tool 4), EMAS Hospitals (N=23)

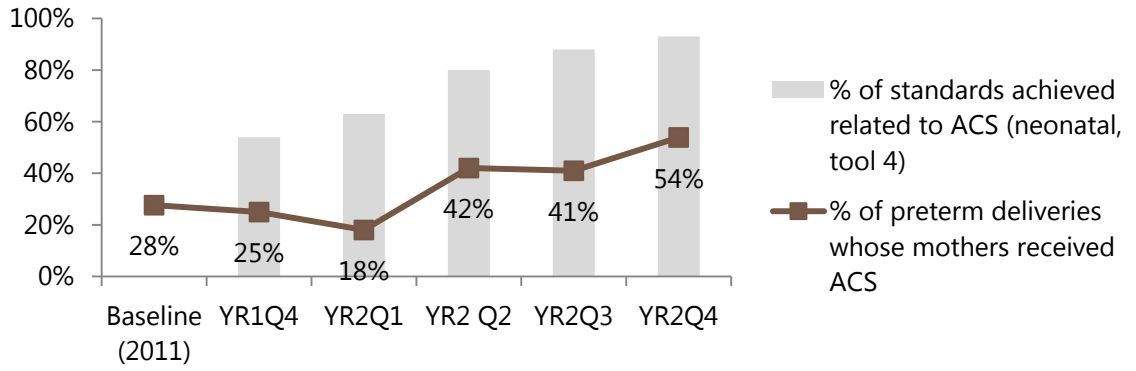
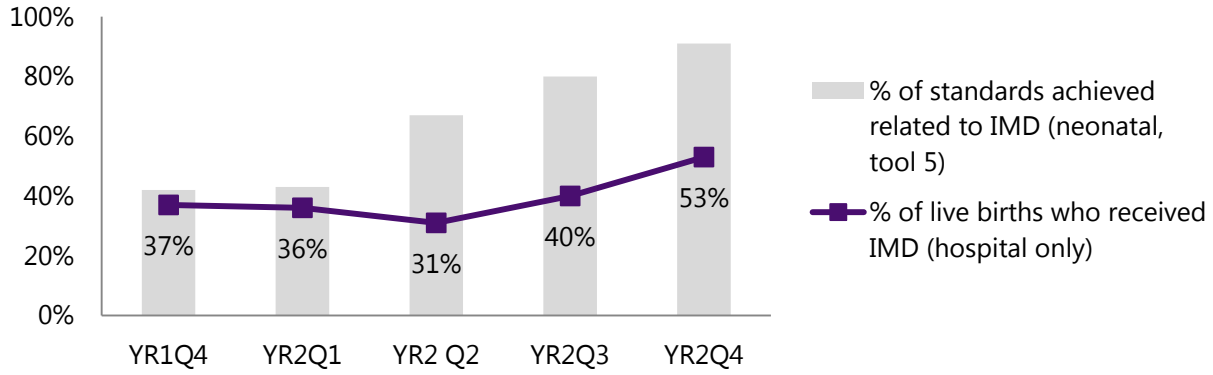


Figure 9: % of newborns breastfed with 1 hour of birth in comparison to facility achievement on related clinical performance standard (Neonatal Tool 5), EMAS Hospitals (N=23)



OBJECTIVE 1: IMPROVED QUALITY OF EMERGENCY OBSTETRIC AND NEONATAL CARE (EMONC) SERVICES IN HOSPITALS AND PUSKESMAS

A. PROGRESS TOWARD YEAR 2 RESULTS

YEAR 2 RESULTS	PROGRESS SUMMARY
Sub-Objective 1.1: High-Impact, Life-Saving Clinical Interventions Implemented In Hospitals And Puskesmas	
Health care providers in Vanguard facilities implementing clinical interventions to standard	**PARTIALLY ACHIEVED:** Compliance of at least 80% of standards by hospitals: 65% achieved maternal and newborn standards, 78% achieved infection prevention standards, and 17% achieved clinical governance standards
SMS-based learning reinforcement implemented to support learning and performance.	**ACHIEVED:** SIPPP is in use across all 10 districts
Effective job aids disseminated to additional facilities, networks and districts	**ACHIEVED:** Job aids have been disseminated, including use of MgSO4 and Helping Babies Breathe
Vanguard facilities prepared to mentor other facilities, networks and key stakeholders.	**PARTIALLY ACHIEVED:** 16 hospitals and 33 puskesmas are ready to begin mentoring in Phase 2
Clinical mentoring activities in high-impact clinical interventions and effective clinical governance practices initiated by Vanguard staff in facilities and referral networks in additional districts	**PARTIALLY DELAYED**: Phase 1 Vanguard facilities will begin mentoring early in Year Three due to the strategic decision to combine P4 and K1 visits. Two Muhammadiyah facilities have initiated mentoring in Phase 2 facilities.
Sub-Objective 1.2: Strong Clinical Governance Practices Established In Hospitals And Puskesmas	
Near-miss and maternal-perinatal death audits implemented routinely in Vanguard hospitals	**PARTIALLY ACHIEVED:** 39% percent of newborn and 47 % of maternal deaths in EMAS facilities were audited. 43% of facilities conduct regularly scheduled near-miss audits.
Mechanisms in place at Vanguard facilities to receive and respond to citizen feedback.	**ACHIEVED:** SIGAPKU is in use in all facilities and all facilities are collecting feedback through suggestion boxes.
Staff of Vanguard facilities prepared to mentor other facilities, networks and key stakeholders in effective clinical governance practices.	**PARTIALLY ACHIEVED:** 16 hospitals and 33 puskesmas are expected to begin mentoring in Phase 2.
The use of CEONC and BEONC standards initiated in additional districts with support from Vanguard facilities	**PARTIALLY DELAYED:** 3 Phase 2 facilities have been introduced to standards. The remainder will be introduced early in Year 3.

B. NARRATIVE DESCRIPTION

Sub-Objective 1.1: High-Impact, Life-Saving Clinical Interventions Implemented In Hospitals and Puskesmas

Mentoring Cycle for Vanguard Facilities

To facilitate the adoption of prioritized clinical interventions and clinical governance approaches in vanguard facilities, EMAS continued its intensive, systematic mentoring cycle that includes a combination of site visits to *Lembaga Kesehatan Budi Kemuliaan* (LKBK) and on-the-job mentoring. As part of the cycle, each hospital and high-volume puskesmas is visited by LKBK staff as part of the mentoring cycle known as *Pendampingan* or P1, *P2, P3, P4, etc.* Mentoring also includes site visits to LKBK, known as K1 and K2 visits, to provide an opportunity to observe practices.

Table 2: Status of Mentoring Cycle, Phase 1 Hospitals

	Hospital	K1	P1	K2	P2	PF1	P3	PF2	PF3	Pre-P4
1	RSUD Majalaya	✓	✓	✓	✓	✓	✓	✓		✓
2	RSUD Waled	✓	✓	✓	✓	✓	✓			
3	RSUD Banyumas	✓	✓	✓	✓	✓	✓	✓		✓
4	RSUD Margono Banyumas	✓	✓	✓	✓	✓*		✓		✓
5	RSUD Soesilo Slawi	✓	✓	✓	✓	✓	✓	✓		✓
6	RSUD Pinrang	✓	✓	✓	✓	✓	✓			
7	RSUD Abdul Manan Asahan	✓	✓	✓	✓	✓	✓	✓		
8	RS Ibu Kartini	✓	✓	✓	✓	✓	✓			
9	RSUD Kanjuruhan Malang	✓	✓	✓	✓	✓	✓	✓		✓
10	RSUD Sidoarjo	✓	✓	✓	✓	✓	✓	✓		✓
11	RSUD Deli Serdang	✓	✓	✓	✓	✓	✓	✓		✓
12	RS PKU Muhammadiyah Medan	✓	✓	✓	✓	✓	✓			
13	RSUD Serang	✓	✓	✓		✓		✓	✓	✓
14	RS Gondang Legi Malang	✓	✓	✓	✓	✓				
15	RS Mitra Delima Malang	✓	✓	✓	✓	✓				
16	RS Adela Tegal	✓	✓	✓	✓	✓				
17	RS Muhammadiyah Tegal	✓	✓	✓	✓	✓		✓		✓
18	RS PKU Muhammadiyah Pinrang	✓	✓	✓	✓	✓				
19	RS Balkes Bokor Malang	✓	✓	✓	✓					
20	RS St Khodijah Sidoarjo	✓	✓	✓	✓	✓	✓	✓		✓
21	RS Anwar Medika Sidoarjo	✓	✓	✓	✓	✓	✓			
22	RS Sembiring Medan	✓	✓	✓	✓	✓				
23	RS Haji Medan	✓	✓	✓	✓	✓				

✓ Completed in Year 1 · ✓ Completed Year 2

Mentoring in Year Two centered on preparing a core group of hospitals and puskesmas to mentor a new set of Phase 2 facilities. In total, EMAS expects 16 hospitals and 33 puskesmas to be prepared take on a mentoring role in Phase 2. While the mentoring cycle is designed in a series of stages, generally beginning with a K1 and ending with a P4 visit, it became clear in Year Two that some facilities could skip certain steps, while others required concentrated support in other areas to advance to the next level. As such, the process of mentoring is not a one size fits all approach.

Table 2 provides an overview of the total types and numbers of mentoring visits conducted throughout the year. In total, nearly 100 mentoring visits by teams of mentors took place in Year Two.

To boost mentoring readiness, EMAS added a series of *Pendampingan Fasilitatif* (PF) visits at key moments in the mentoring cycle. PF visits are conducted by a smaller mentoring team with the purpose of lessoning the time between mentoring visits and helping to bolster mentoring readiness. A series of PF visits were carried out throughout the year

To ensure Vanguard facilities were as prepared as possible to begin mentoring, EMAS made the strategic decision to combine the final P4 visit with the K1 visit of Phase 2 facilities. With the understanding that mentoring requires a set of skills in and of itself, EMAS put in place pre-P4 visits as a precursor to the formal P4/K1 visit. EMAS also developed a set of guidelines to facilitate the mentoring process in Phase 2. The pre-P4 visit provides specialized support around the mentoring process. Overall, feedback was positive from the 10 hospitals that participated in the pre-P4 visit, with hospitals reporting that they have a much clearer understanding of their role in and the process of mentoring others. For a variety of reasons, some facilities were not yet ready to advance to the pre-P4 visit and therefore did not receive pre-P4 visits prior to the end of the year. These visits will occur once those facilities have met more of the Vanguard readiness criteria.

In addition to preparing the original set of 23 Phase 1 hospitals, EMAS's lead Phase 1 mentor, LKBK, provided targeted mentoring support to two Muhammadiyah hospitals in Jakarta, Cempaka Putih and Pondok Kopi, during Year Two. The Muhammadiyah network of hospitals across Indonesia will be a recipient of EMAS mentoring in Phase 2, with Cempaka Putih and Pondok Kopi leading the mentoring process for hospitals within their network. Near the end of Year Two, Muhammadiyah finalized a mentoring approach for their network and held a large meeting of its network to share the clinical governance and mentoring model. Muhammadiyah signed an MOU with its network and has targeted four initial health facilities (RS Pati Rapih, RS Bethesda, RS PKU Muhammadiyah and RS Lempuyang Wangi) for the first round of mentoring beginning in Phase 2. Cempaka Putih, with strong hospital leadership, progressed quickly and began hosting visits in the last quarter of the year. Pondok Kopi will begin hosting visitors for the K1 and K2 visits early in Year Three.

Finally, in addition to mentoring Phase 1 hospitals, EMAS initiated the mentoring process for three Phase 2 hospitals in West Java in the last quarter of Year Two. Table 3 provides an overview of the mentoring cycle for these hospitals.

Table 3: Status of Mentoring Cycle, Phase 2 Hospitals

	Hospital	K1	P1	K2	P1	P2	P3	P4
	RSUD Cibinong	✓	✓					
	RSUD Ciawi	✓	✓					
2	RSUD Karawang	✓	✓					

Improve provider skills for Newborn Care

Several gaps were identified in Year 1 and Year 2 for the provision of newborn care. Gaps included both the use of outdated and in some cases, harmful practices as well as a failure to use evidence-based interventions to care for sick newborns. In Year 2, EMAS prioritized improving skills for targeted, high-impact interventions to improve the quality of newborn care using various approaches.

In February 2013, EMAS held a national Newborn Technical Update to address knowledge gaps around evidence-based practices, with a focus on practices for caring for healthy and sick newborns

and special sessions on managing birth asphyxia, infection and complications from being born preterm or with low birth weight. The event was held in collaboration with the MOH and the Indonesian Pediatrics Association (IDAI) and was attended by over 360 participants throughout Indonesia. Several provincial and district-level participants subsequently conducted mini-technical updates, in various formats, to share what they learned at the event in the latter half of Year 2. As a result of the technical update meeting IDAI designated one pediatrician in each province to provide monitoring and support around newborn care in EMAS target facilities. The designated pediatricians currently routinely visit the Phase 1 hospitals, and they are members of the Pokjas in each province.

EMAS also initiated a new collaboration with Massachusetts General Hospital (Mass General) and Boston Children's Hospitals in Year 2 to improve the quality of newborn care in EMAS target facilities. The activity provides EMAS with supplemental, intensive mentoring support through rotations of US-based pediatricians. Year 2 activities focused on defining the model for the program, based on inputs and recommendations from US-based physician, Dr Grace Chan, as well as physicians from Mass General and Boston Children's Hospitals. EMAS also developed a standardized set of tools, Decision Support Tools, which volunteers will use as a basis for mentoring. Implementation of this mentoring approach will begin early in Year 3.

SMS-based learning support mechanism for providers (SIPPP)

EMAS initiated an SMS learning program, *Sistem Informasi Penguatan Pembelajaran dan Performa (SIPPP*) to reinforce knowledge around selected interventions and to test provider knowledge retention. During Year Two, EMAS developed learning modules around key interventions related to maternal and newborn care. The system was launched early in the year during a meeting held by the MOH, with provincial stakeholders participating via webcast. By the second quarter of the year, the system was rolled out across all ten districts.

Since being rolled out, 3,551 midwives have registered to take part in the SMS program across the six EMAS provinces. Overall, response rates to quizzes remain low (26 percent), with a high of 39 percent in Banten and a low of nine percent in North Sumatra. Of those who did respond to quizzes, an average of 89 percent answered the quiz correctly.

As EMAS has gained experience in the facilities, it has become increasingly evident that addressing gaps in knowledge is of lower priority than other interventions. In Year Three, EMAS will re-allocate funds designated for SIPPP towards including all puskesmas in SijariEMAS as well as efforts to improve MgSO4 and antibiotic provision in all puskesmas.

Ensure facilities possess essential equipment and supplies for managing maternal and newborn complications

Assessments of EMAS facilities have shown gaps in equipment, supplies and in some cases, basic infrastructure. In Year Two, EMAS worked with the DHO to ensure necessary commodities were budgeted for and provided to facilities. In some cases, for example in certain Vanguard facilities, EMAS also provided direct support to facilities to procure needed equipment and supplies such as emergency trollies.

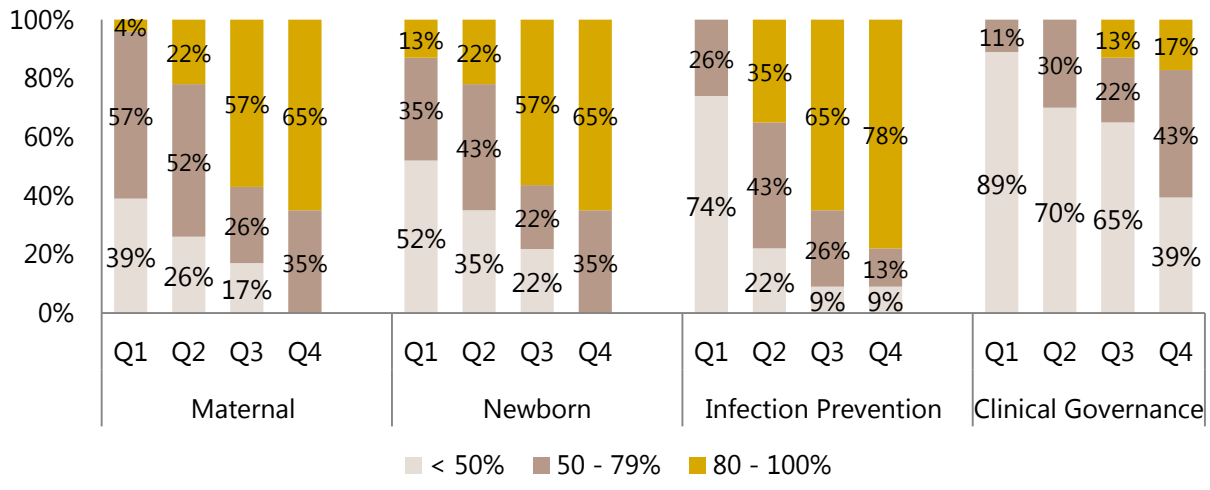
Sub-Objective 1.2: Strong Clinical Governance Practices Established In Hospitals and Puskesmas

Monitor hospital performance using performance standard tools

In Year Two, EMAS facilities began routinely monitoring performance using a set of CeONC/BeONC performance standard tools. These tools provide facilities with quantitative measures regarding compliance with key clinical and governance standards aimed at ensuring quality care. The use of these tools also enables EMAS to quantify progress made in facilities as a result of EMAS mentoring and support. This year, improvements were seen across all intervention areas. While all facilities aim to achieve 100 percent compliance with all performance standards, a prerequisite for facilities to be deemed ready to mentor includes 80 percent compliance in four key categories: maternal, newborn, infection prevention and clinical governance standards.

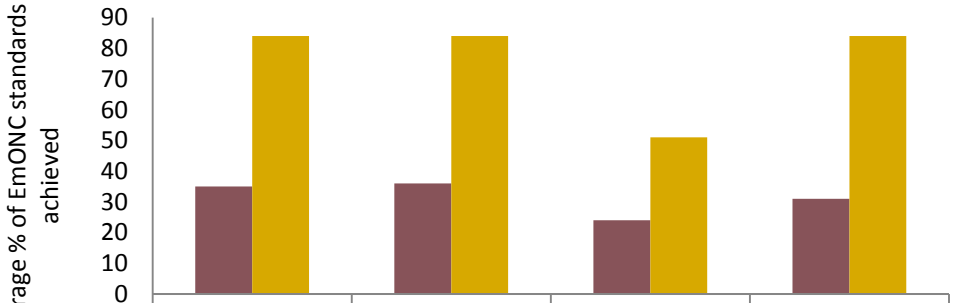
Throughout the year, greater and greater percentages of facilities complied with performance standards. Significant improvements can be seen across all four categories from Quarter 1 through the end of the year, with strongest improvements seen in the percent of facilities complying with infection prevention and maternal standards (Figure 10).

Figure 10: Percentage of Standards Achieved by EMAS Hospitals, Year 2 (N=23)



A breakdown of the performance by hospital shows variation in compliance with standards (Annex 2). While variance is seen across facilities, average performance across hospitals for maternal, newborn and infection prevention standards is promising. Average hospital compliance is 84 percent in each of these areas (Figure 11 below). Overall compliance in the performance of clinical governance standards remained lower than compliance with standards in other areas. While EMAS has seen significant and steady improvement in clinical governance scores, the average score across all hospitals is 51 percent. To a large extent, lower performance in governance standards is expected at this stage in the program, as clinical governance-related standards require larger, institutional-level change that takes time to bring about.

Figure 11: Average % of EmONC standards achieved, Hospitals (n=23)



	Maternal standards	Neonatal standards	Governance standards	Infection prevention standards
Baseline Assessment (2012)	35	36	24	31
Most recent assessment (2013)	84	84	51	84

At the end of Year Two, only one hospital, RSUD Margono was complying with at least 80 percent of all four clinical performance standards (Annex 2). Low achievement in clinical governance standards continues to hold back other hospitals from excelling in all four performance standard categories. While nine hospitals achieved at least 80 percent compliance with standards across maternal, newborn and infection prevention categories, only four hospitals achieved 80 percent compliance with standards for clinical governance. When disaggregated by technical area and tool, recent performance assessments show hospitals are complying with the highest percentage of performance standards in the following areas: AMSTL, neonatal resuscitation, antenatal steroids and early and exclusive breastfeeding (Figure 12). A review of hospital-by-hospital performance indicates that RSUD Margono, RSUD Lasinrang in Pinrang and RSUD Kanjuruhan Malang in Malang are top performers in complying with performance standards. In both of these cases, average overall scores in performance standards have been boosted by strong compliance in clinical governance areas.

A review of puskesmas achievement shows similar gains in compliance of maternal and neonatal standards (Figure 13). Average compliance with standards across all puskesmas is up 49 points from the baseline assessment conducted in 2012. Progress in infection prevention has also been significant, with average scores increasing 37 points over baseline.

Figure 12: Hospital Achievements in Clinical Standards, Disaggregated by Technical Area and Tool, Assessment September 2012 (N=23)

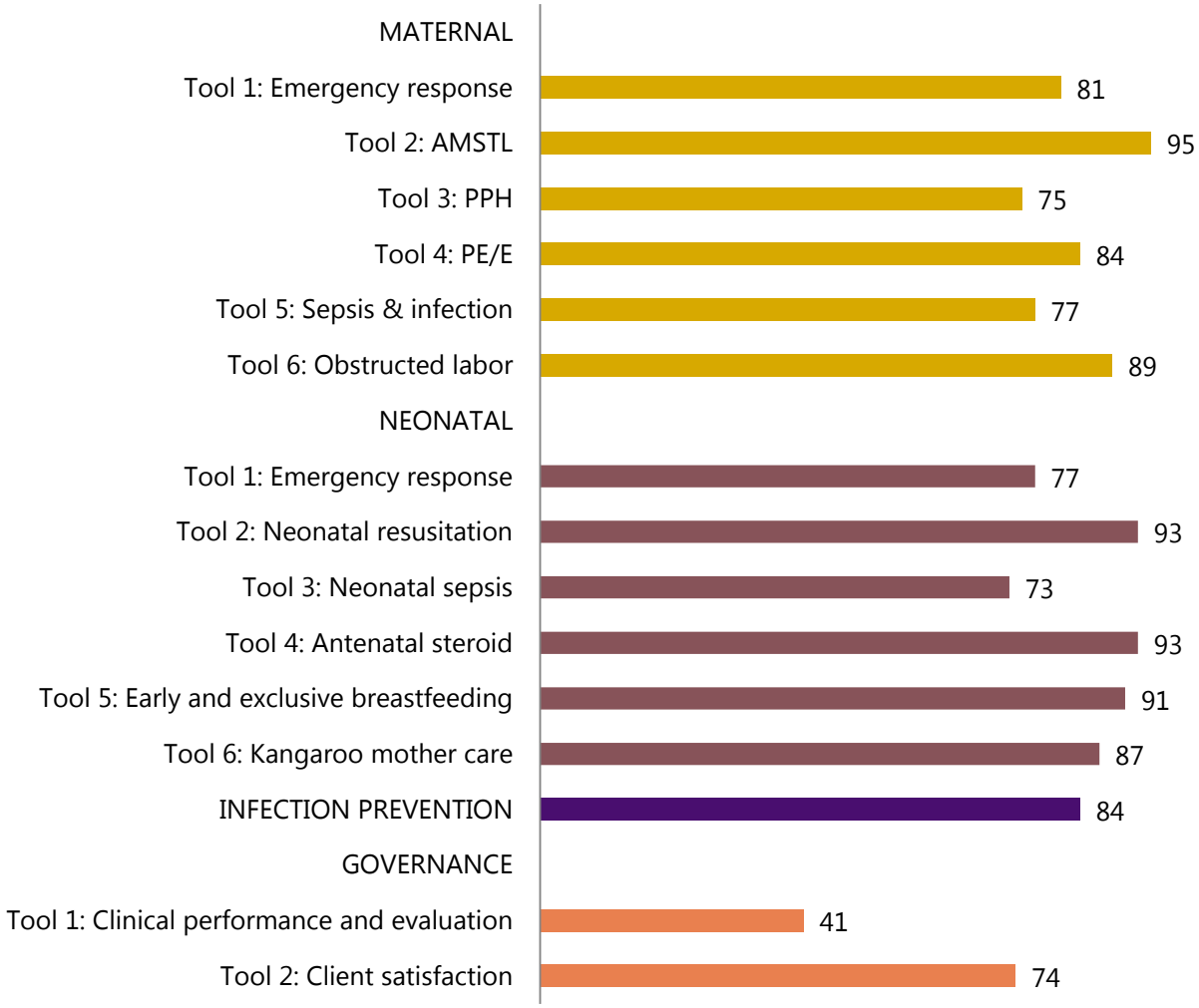
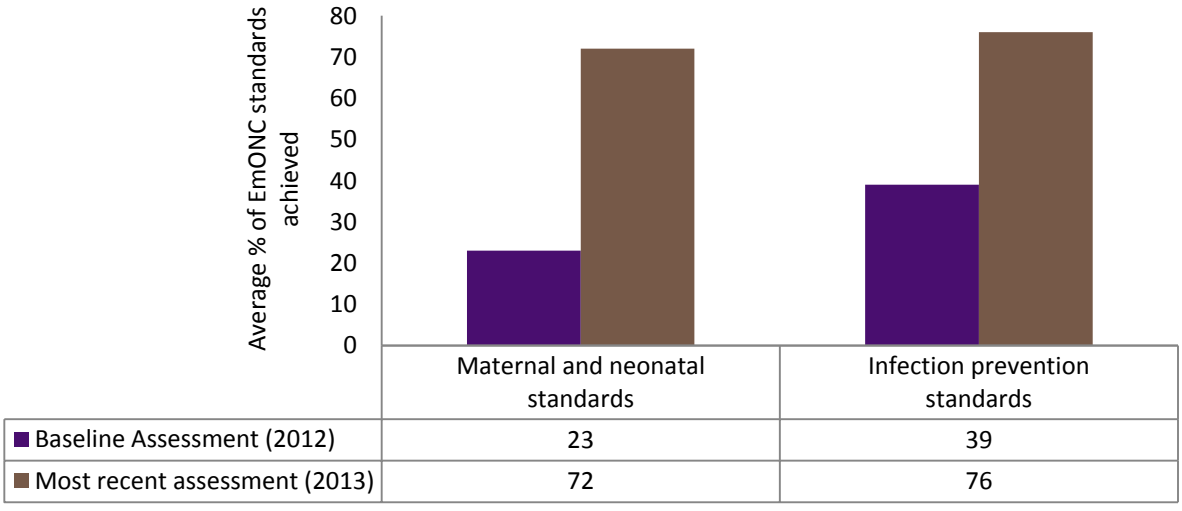


Figure 13: Average % of EmONC standards achieved, Puskesmas (n=93)



Near-miss and death audits introduced

In Year One, EMAS facilities were introduced to the concept of near-miss and perinatal death audits. In Year Two, EMAS focused on mentoring facilities in how to conduct audits and worked to increase the frequency of audits. In collaboration with professional organizations, WHO and the MOH, EMAS also developed a standardized approach and operational guidelines for conducting near-miss and maternal/neonatal death audits.

Overall, progress in conducting near-miss and death audits on a regular basis has been slower than desired, as EMAS has struggled to change the culture within facilities to that of one that is more open to the audit process. While PMP indicators show only slight increases in the number of facilities that conduct audits on *every* maternal and newborn death, the percent of deaths audited in EMAS facilities shows progress is being made. In total, 39 percent of newborn and 47 percent of maternal deaths in EMAS facilities were audited in Year Two (Table 4).

Table 4: % neonatal and maternal deaths audited in EMAS facilities, Year Two

Facility	Neonatal deaths > 2000 grams			Maternal Deaths		
	Cases	Cases Reviewed by Facility	Percentage of Cases Reviewed	Cases	Cases Reviewed by Facility	Percentage of Cases Reviewed
Hospital	640	252	39%	161	77	48%
Puskesmas	9	3	33%	2	0	0%
TOTAL	649	255	39%	163	77	47%

Progress in near-miss audits was also seen in Year Two. Near-miss audit rates have significantly increased over baseline, with overall rates increasing from 13 to 43 percent (Table 5). While cultural changes will take time to foster, EMAS implemented several different strategies in Year Two to improve the regularity and quality of near-miss and death audits. EMAS has seen the most success in encouraging simplified case reviews to help promote the principles behind death audits. EMAS also modeled audit processes during routine visits by midwives and nurses (during PF visits) and used EMAS Clinical Coordinators to reinforce these practices during visits.

Table 5: % of EMAS hospitals that conduct regularly scheduled near-miss audits (N=23)

Hospital Type	Baseline	Year 2
Private	0%	25%
Public	27%	64%
Overall	13%	43%

Progress this year has also varied by facility. RSUD Margono conducts weekly audits on maternal and neonatal deaths and in RSUD Banyumas, the perinatology unit conducts regular audits. While in RSUD Soeselo Slawi, RSUD Majalaya and RSUD Serang, audit meetings are led by specialists but have been expanded to include midwives, nurses, residents and students. These examples are encouraging and EMAS has begun to see the cultural shifts that must occur for audits to take place on a regular basis. Still, the frequency of near-miss audits still lags behind death audits. A key challenge moving forward will be to assist facilities with analyzing data pertaining to near-miss audits.

Development of dashboard indicators within each facility

EMAS uses dashboards as one tool within a set of interventions aimed at building strong clinical governance systems. Dashboards and dashboard indicators help facilities monitor clinical practices, adverse events and operational factors affecting the quality of care. In Year Two, EMAS focused on developing dashboard indicators for each facility and supporting facilities to maximize use of data. By the end of the year, all 23 hospitals had dashboards in place.

However, despite the existence of dashboards, EMAS has seen less progress in using dashboard data to inform management and decision-making processes. Overall, the use of data to make decisions that affect the quality of services requires a behavioral shift that is not quickly brought about. It requires both time and the support and involvement from hospital management, specialists and lead clinical staff. In general, facilities have strong support from middle-level management, but lack adequate support from the highest levels of facility management, including the specialists.

Throughout the year, EMAS continued to support facilities to strengthen their use of dashboard data. EMAS focused support around working with facilities to analyze data, identify gaps and discuss areas for improvement with facility management. As the year progressed, improvements were seen in several facilities. RSUD Serang stood out as a leader in the use of dashboards early on. While in RSUD Margono, the hospital director liked the dashboard approach so much that the hospital now uses dashboards in other units outside of the maternal and neonatal wards. RSUD Kanjuruhan Malang has also successfully used dashboards. In this case, the hospital Quality Improvement Team was able to use dashboard data to convince hospital management to re-organize the facility, including the perinatal ward and delivery room.

In addition to providing additional one-on-one support directly to facilities to improve the use of dashboards, EMAS also developed guidelines outlining the optimal use of dashboards in Year Two. To allow for inter-facility comparison and to improve the quality of dashboards, EMAS also established a minimum set of indicators for which all facilities will track moving forward.

Establishing citizen feedback mechanisms to hold hospitals and puskesmas accountable for quality CEONC and BEONC services

To improve the quality of emergency services as well as accountability for providing quality care, EMAS introduced the concept of service charters and an electronic citizen gateway (see Sub-Objective 2.2) for providing feedback about the perceived quality of care in Year One to districts and facilities.

In Year Two, EMAS facilitated the process of getting service charters signed in all ten districts among facilities, local government and civic fora. While the approach for developing and finalizing charters varied by facility, EMAS supported teams within each facility to draft, solicit feedback, finalize and publicize the service charters. Throughout the year EMAS worked to ensure that service charters, as one component of EMAS's efforts to improve accountability within facilities, were interlinked with other activities to improve accountability. Service charters were developed and socialized with significant support from civic forums. In addition, in Year Two EMAS also focused on mentoring Pokjas to take on their role of helping to routinely monitor and resolve areas in support of service quality improvement.

A midwife wraps a newborn at Budi Kemuliaan Maternity and Children's hospital. Budi Kemulian hospital serves as a model facility for maternal and newborn care. Budi Kemuliaan mentors other hospitals in Indonesia to improve the quality of maternal and newborn care as part of the USAID-funded Expanding Maternal & Neonatal Survival program. JHPIEGO INDONESIA/ Syane Luntungan (JAKARTA)

OBJECTIVE 2: INCREASED EFFICIENCY AND EFFECTIVENESS OF REFERRAL SYSTEMS BETWEEN COMMUNITY HEALTH CENTERS AND HOSPITALS

A. PROGRESS TOWARD YEAR 2 RESULTS

YEAR 2 RESULTS	PROGRESS SUMMARY
Sub-objective 2.1: Referral system strengthened and functioning optimally	
Referral performance standards finalized and implemented in 10 referral networks.	**ACHIEVED:** Assessments were carried out in 10 districts.
Operational guidelines for referral systems finalized and implemented in 10 referral networks.	**ACHIEVED:** Operational guidelines have been finalized and guidelines are in use in 10 districts.
MOUs (PK) in place in 10 districts to improve coordination and collaboration of public and private facilities.	**ACHIEVED:** All Phase 1 hospitals and puskesmas in all 10 districts have signed PKs in place.
ICT-based "referral exchange" implemented in 10 districts and expanded to at least one new district	**ACHIEVED**: SijariEMAS is in use in all 10 Phase 1 districts. Two Phase 2 districts have the system in place.
Sub-Objective 2.2: Citizens and CSOs hold providers, facilities and local government accountable for high-quality services	
Citizen gateway functioning in 10 districts.	**ACHIEVED:** SIGAPKU is in use in all EMAS Phase 1 hospitals and puskesmas
Service charters developed and signed in 10 districts	**ACHIEVED:** Service charters have been signed in all EMAS facilities in all 10 districts (see activity 1.2 above).
Citizen report cards implemented to monitor satisfaction with provision of EmONC services	**ACHIEVED:** Pinrang, Bandung, and Cirebon implemented and disseminated findings of CRCs.
Civic forums participating in service charter development, CRC implementation and Jampersal socialization in 10 districts.	**ACHIEVED**: Forums are actively engaged in all 10 districts
Sub-Objective 2.3: Financial barriers to access and utilization of services by the poor and vulnerable minimized	
CSOs actively promote citizen enrollment in and private facility use of social insurance	**ACHIEVED:** All sub-districts have held meetings to socialize *Jampersal*. MKIAs are providing one-on-one support to communities.
Survey conducted to monitor increases in enrolment rates	**POSTPONED:** Will not be conducted, per discussions regarding program learning; may be revisited pending roll out of universal health coverage

B. NARRATIVE DESCRIPTION

Sub-objective 2.1: Referral system strengthened and functioning optimally

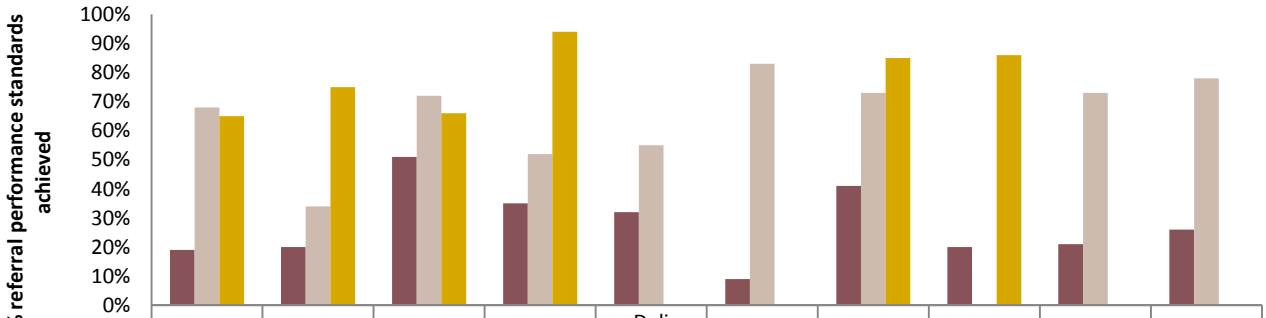
Obtaining consensus on and operationalizing referral performance standards to improve the quality of referral

To improve the quality of referral and address the lack of national referral standards and guidelines, EMAS supported the drafting of performance standard tools (*alat pantau kinerja)* and operational guidelines that outline procedures for incoming referral notification, the availability of health providers 24/7, and treatment protocols for referral. The performance standard tools enable districts to quantitatively measure the effectiveness of their referral systems.

The process of developing, refining and implementing the tools and guidelines has required significant effort at both district and national levels. The tools were drafted by EMAS in Year One. In Year Two, EMAS began the process of soliciting feedback and input on the draft tools and guidelines through a series of meetings with BUK and other stakeholders at various levels and via a national workshop hosted by EMAS early in Year Two. EMAS continues to seek full endorsement from the national MOH on the performance standard tools.

After an initial round of feedback and refinement to the tools and guidelines, EMAS moved forward with orienting DHO and health facility staff in each district to the performance standard tools and field tested the materials in the ten EMAS districts. After the first round of assessments, EMAS held workshops with DHOs and stakeholders to identify strategies to overcome gaps and achieve referral performance standards. With support from EMAS, subsequent assessments were conducted in the last two quarters of Year Two to assess progress made. Compared to the first assessment, all districts have made significant progress in complying with referral standards (Figure 14). Four districts have achieved over 80 percent compliance with standards, with the highest achievements seen in Cirebon, Serang, Pinrang, and Malang, with Malang achieving a 74 point improvement from the first to the second assessment. While progress in Deli Serdang, Banyumas and Asahan has been slowest of all districts, all have made steady and significant improvements compared to the initial assessment. In addition, district scores mask variation in performance within districts; for example, Deli Serdang is marked by high levels of compliance in some puskesmas and rather low compliance in others, thereby lowering the average performance across the district.

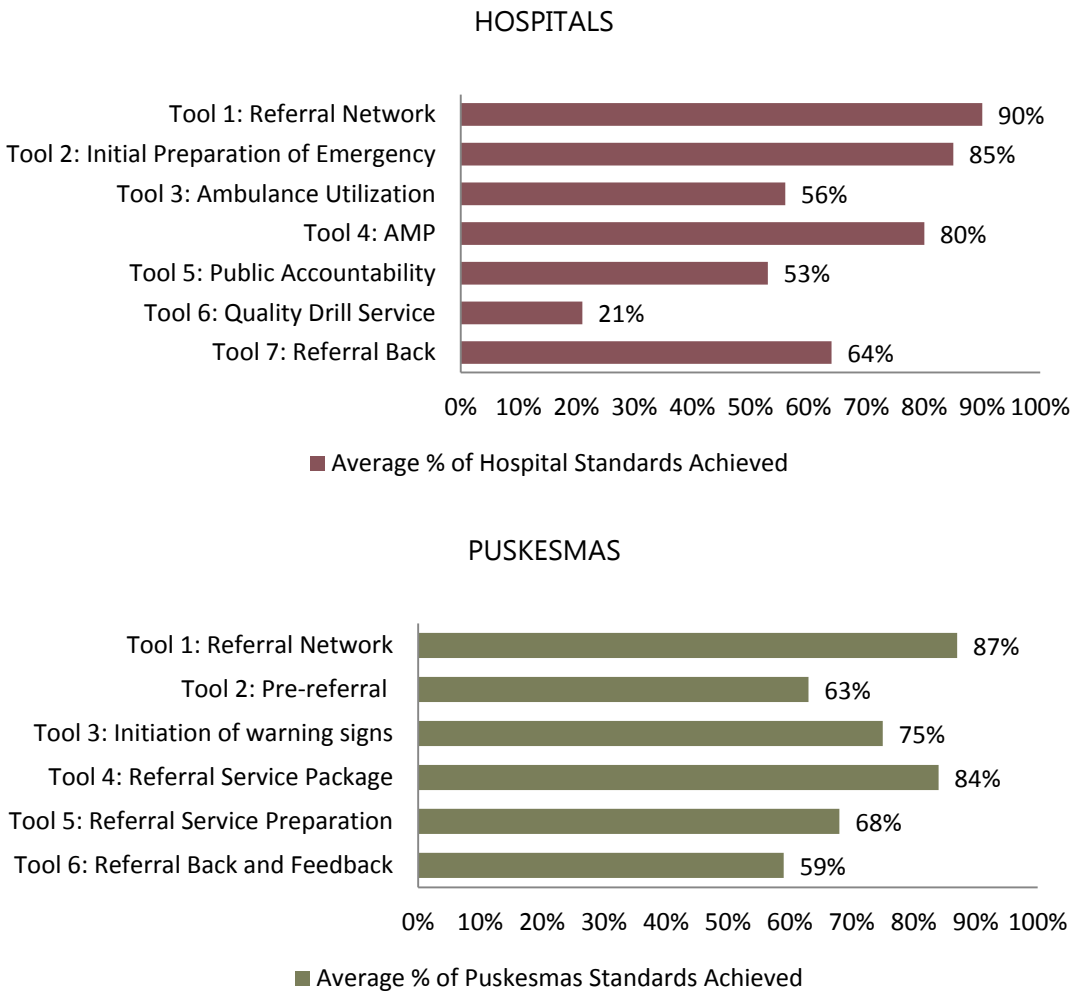
Figure 14: Compliance with Referral Performance Standards, Year 2, Assessments 1, 2, and 3



	Asahan	Bandung	Banyumas	Cirebon	Deli Serdang	Malang	Pinrang	Serang	Sidoarjo	Tegal
YR2, Q2	19%	20%	51%	35%	32%	9%	41%	20%	21%	26%
YR2, Q3	68%	34%	72%	52%	55%	83%	73%		73%	78%
Y2, Q3	65%	75%	66%	94%			85%	86%		

Annex 2 shows detailed progress in the measures of referral system performance. Across all measures included in the referral performance standards overall, hospitals show highest achievement in preparedness of referral networks and preparing for emergencies (Figure 15). While Puskesmas show highest achievements in referral network and availability of referral service packages.

Figure 15: Disaggregation of referral standards achievement by tool for EMAS Districts (n=10), Year Two



While district health office teams are responsible for conducting regular assessments on referral systems, EMAS provided continued support and guidance throughout Year Two to districts and Facilitative Supervision teams to ensure assessments were conducted appropriately. Despite a few challenges in rolling out the tools, such as ensuring the Facilitative Supervision teams conducting the assessments were well-functioning and that the tools were implemented properly, the referral standard tools have been well received by DHOs. After technical support from EMAS on how to use the tools and small refinements to the materials themselves, overall DHOs have found the tools to be user-friendly and have noted that they outline a clear pathway to improve referral system performance.

Near the end of Year 2 and in preparation for Phase 2 expansion, EMAS identified Vanguard Referral Districts who subsequently put in place mentoring teams who will be responsible for mentoring Phase 2 sites. To prepare the referral mentoring teams, three-day workshops were held to boost readiness and to refine mentoring plans. The workshops focused on mentoring for all aspects of the referral system, including the referral standards, MPAs, ICT components and relevant governance and accountability entities.

A life saved in Aras Kabu, North Sumatra

In Aras Kabu, North Sumatra, Yusni, 18 years old and 34 weeks pregnant with her first child, nearly lost her life. It was a hot Sunday afternoon in May 2013 when her family discovered something was seriously wrong. Yusni had fallen to the ground and was seizing uncontrollably. Unable and afraid to move her daughter, Yusni's mother, Ibu Sakdiah, ran to the nearest puskesmas for help.

The midwives on duty, Pitnawati and Piolina told Ibu Sakdiah to bring Yusni to the puskesmas immediately for treatment. But when they heard the distant sounds of a man, Yusni's husband, screaming that his wife was unconscious, the midwives knew they had to act quickly. They grabbed what equipment and supplies they could and rushed to Yusni's home, just 500 meters away.

When Pitnawati and Piolina entered Yusni's home, which had quickly filled with terrified family and neighbors, they found Yusni lying on the floor. They immediately recognized that Yusni was suffering from eclampsia. Eclampsia is the result of untreated high blood pressure during pregnancy – it can result in kidney and liver damage, and ultimately, death. Over the course of merely a few seconds, time began to stand still and Pitnawati worried if she could save Yusni. Could she remember what to do? Could she do it properly?

Fortunately, just weeks earlier, the midwives had participated in drills to prepare for exactly this type of emergency in their puskesmas. The puskesmas has been receiving support from the United States Agency for International Development (USAID) program, Expanding Maternal and Neonatal Survival (EMAS), to help improve the quality of emergency maternal and newborn care.

Without hesitation Pitnawati and Piolina began treating Yusni. With the steps of the emergency drills still fresh in their minds, the midwives maintained her airway", administered an IV drip and provided a dose of magnesium sulfate. Yusni's seizures ended and her condition stabilized. Yet the midwives knew, as with any case of eclampsia, Yusni needed to deliver her baby soon. They immediately notified the nearest hospital in Deli Serdang, nearly an hour away, and arranged for an ambulance to take Yusni there to deliver her baby.

Yusni made it to the hospital, received proper care and today, Yusni and her husband Zainuddin have a healthy baby boy. They named him Ayusni Dafa.

Many women and babies are not as fortunate as Yusni and her son. Each year, more than 10,000 women die in Indonesia due to complications from pregnancy and childbirth. Eclampsia, the condition which nearly killed Yusni, is the second leading cause of maternal death in Indonesia. Yet eclampsia and other major causes of maternal death can be prevented if women receive timely and appropriate care. Emergency drills and other key practices to improve the quality of emergency care used by the EMAS program are working to ensure that puskesmas and hospitals are prepared in crises like this. With confident and well-prepared midwives, doctors and health facilities, like the ones who came together to save Yusni's life on that hot Sunday afternoon in Aras Kabu, more mothers and their babies can survive pregnancy and childbirth.

Mrs. Yusni holds her newborn, Ayusni Daffa, in Aras Kabu, Deli Serdang, June 1, 2013. Yusni suffered severe eclampsia and nearly died. Yusni received life-saving treatment by two midwives that were mentored by the USAID-funded Expanding Maternal & Neonatal Survival program. JHPIEGO Indonesia/Hartono Rakiman (NORTH SUMATRA)

Consensus on PKs to support referrals between public and private facilities

To govern the referral network and improve collaboration and coordination among facilities as well as to integrate private facilities into the referral system, EMAS supported the process of drafting *Perjanjian Kerjasama* (PKs) to define the roles, responsibilities and expectations of both private and public hospitals and health centers, the local government and the civic forum.

In Year Two, EMAS facilitated the process of drafting and ensuring that all facilities had signed on to their network's PK. Mid-Year, EMAS held a national-level review of PKs where the recommendation to involve a wider group of stakeholders in the development of the agreements was made. EMAS subsequently modified its approach based on this recommendation. In addition, assessments conducted by Facilitative Supervision teams as part of the referral performance standards near the end of the year highlighted shortcomings in some PKs. For example, private midwives were not included in some PKs and some lacked reference to relevant communication channels. Where needed, districts adjusted PKs to correct identified issues. By the end of Year Two, all facilities had signed on to a PK.

Implement the "referral exchange" to support improved referral services - SijariEMAS

The referral exchange mechanism (SijariEMAS) improves the efficiency of referrals by improving communication between puskesmas and the referral hospital, while at the same time ensuring hospitals can anticipate incoming referrals. Midwives send messages to the system and the message is subsequently routed to the hospital.

In Year One, EMAS designed the system architecture. Year Two was dedicated to rolling out the system across all ten Phase 1 districts. In December 2012, the system was launched nationally by the head of PUSDATIN MOH, with virtual participation from provincial and district officials. After the national launch, EMAS introduced and modeled the system to district stakeholders, installed system hardware and software components and trained facility staff on how to operate the system to facilitate a referral. All EMAS Phase 1 districts are currently using SijariEMAS. In preparation for Phase 2, EMAS rolled out SijariEMAS to two Phase 2 districts in West Java, Bogor and Karawang. In both of these districts, local governments have provided funding to implement the system beyond EMAS supported facilities.

In total, 6,717 referral cases have been facilitated through SijariEMAS. Learning to use SijariEMAS and optimize its functionality to improve referral processes takes time. Table 6 below presents data for three districts in which the system has been running the longest. Analysis of systems operating the longest provide better insight into trends in use and performance as compared to districts that have only been using the system for a short time. Overall, patients using Jampersal is high, with 80 percent of referral cases using the social insurance mechanism. Response time, while affected by various factors, is also encouraging, with average response times across the three districts at less than 10 minutes in 80 percent of the cases. Use of ambulances remains low at an average of 36 percent.

Table 6: SijariEMAS Referral Data, Year 2 (n=4382)

District	# of cases	Percent Jampersal	< SOP (10 min)	>SOP (10 min)	Transport Ambulance
Bandung	538	72%	79%	21%	32%
Cirebon	3447	75%	93%	7%	35%
Serang	397	92%	68%	32%	40%
Average	4382	80%	80%	20%	36%

Based on Phase 1 experience, EMAS is currently working to streamline and refine the SijariEMAS system. Technical improvements planned include simplifying the SMS format to make the process more user-friendly, as well as improving some aspects of the system infrastructure to improve functionality. In addition, some challenges with using the system have highlighted the need for clearer operating policies and procedures within facilities in regard to responding to referral cases, such as ensuring adequate human resources to respond to a referral. EMAS is currently working to resolve these challenges.

Overall, SijariEMAS has received high-level attention and widespread interest this year. The system was promoted through the National eHealth Road Map as well as in materials for the WHO Commission on Information and Accountability for Women's and Children's Health. In March 2013, SijariEMAS was demonstrated during the Indonesia Health Information Forum, during which the Vice Minister of the MOH observed and tested the system. Near the end of Year Two, SijariEMAS was modeled in Banten for the Vice-Governor, and high-level MOH participants were also in attendance. The Minister of Health saw a SijariEMAS demonstration during the launch of the National Action Plan on Reducing MMR. The MOH has expressed interest in using the system as one tool to reduce maternal and neonatal mortality. In addition, provinces outside of the EMAS target areas have requested technical assistance from EMAS to implement SijariEMAS, including Central Sulawesi, West Sumatra, and DKI Jakarta.

Strengthen existing hospital-based emergency call centers

In Year Two, the need to further facilitate communication between midwives and the hospital during the referral process became clear. To address this, EMAS moved forward with plans to strengthen existing

emergency call centers at hospitals or within EMAS districts that are part of the national SPGDT initiative. Integrated with SijariEMAS, strengthened call centers fill key gaps in communication by enabling voice communication, especially during complicated referral cases. Complementary to SijariEMAS, the call centers provide a direct line of communication to doctors within hospitals to obtain stabilization advice, make automatic follow-up calls during transport, and enable data collection that is not currently possible through standard phone systems.

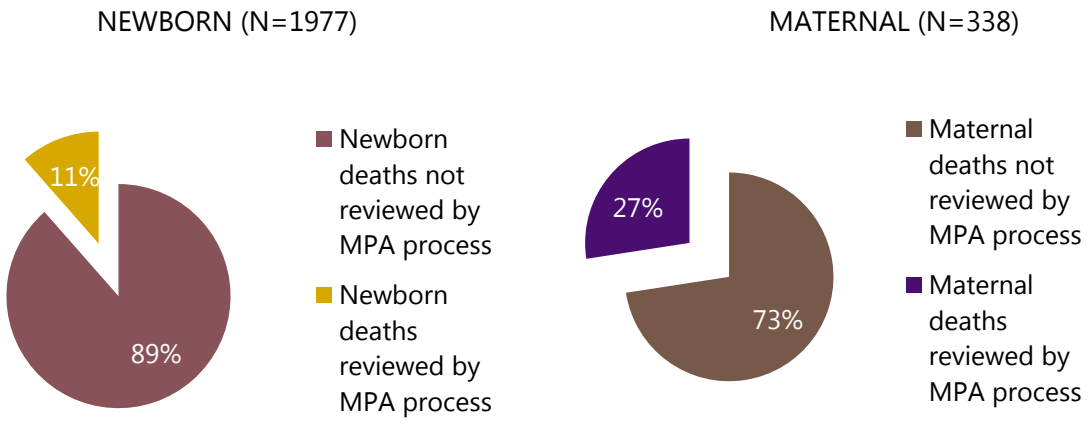
The majority of activities in Year Two centered around designing the call center architecture and the platform infrastructure. Late in the year, EMAS began piloting two district-based call centers in Bogor and Karawang, as well as a hospital-based system in RSUD Soeselo in Tegal district. Both Bogor and Karawang have covered all related costs for installing and operating the system from their own budgets. In Tegal, EMAS funded the costs of the hardware and all other costs covered were covered with local funding.

Improve maternal and perinatal audit (MPA) processes

Maternal and Perinatal audits help districts identify health system weaknesses along the referral pathway that may have contributed to maternal and perinatal deaths. While policies in place mandate such audits, assessments in Year One showed that no district conducted a full audit on every maternal death.

In Year Two, EMAS helped districts implement maternal and perinatal death audit processes to increase the regularity of audits. Overall, EMAS has struggled to make solid progress in improving the frequency and quality of district-level MPAs, albeit with some variation in progress seen across districts. Across all EMAS districts, 12 percent of newborn and 30 percent of maternal deaths were audited (Figure 16). While the MPA process includes deaths across the entire district, including deaths in facilities not supported by EMAS, a review of deaths audited in EMAS facilities is more promising, as discussed above in Sub-Objective 1.2.

Figure 16: Percentage of district-wide maternal and newborn deaths reviewed by MPA process



In recognition of the challenges in implementing regular audits, activities this year centered on ensuring that districts were oriented to and able to implement to the new 2010 guidelines appropriately. In Quarter 4 of the year, EMAS held MPA workshops with provincial and district staff to reinforce the 2010 guidelines and processes and to agree on next steps to improve the audit process. In Year Three, districts are expected to appoint smaller audit teams, led by an audit "expert" and will revise other processes to be consistent with the 2010 guidelines.

Sub-Objective 2.2: Citizens and CSOs hold providers, facilities and local government accountable for high-quality services

Ensure mandated public forums for citizen feedback are operational and effective

EMAS is developing and introducing mechanisms that enable citizens to hold facilities and local government accountable, namely civic forums, the Citizen Gateway (*SIGAPKU*) and Citizen Report Cards (CRCs), which each play a role in collecting citizen feedback. In Year Two, EMAS focused on both fully implementing and optimizing these interventions, while ensuring that all three were well-linked with one another and other program components, such as Pokjas. Year Two progress for each of these activities is described below.

Civic Forums

Civic forums, also called *Forum Masyarakat Madani* (FMM), help expand public participation and serve as a community-based body for monitoring the quality of services. In Year Two, civic forums were used as a mechanism for discussing the quality of services provided by facilities, as a means to seek input into service charters and CRCs, and for coordinating citizen involvement and engagement.

In Year Two, civic forums were active in all EMAS districts. Throughout the year, EMAS focused on strengthening the groups to become more effective at carrying out their primary functions (eg. developing maternity savings funds, participating in collecting citizen feedback, conducting blood donor events, and conducting advocacy around regulations at multiple levels - from the village level up to the Bupati) In addition, EMAS held a held a national civic forum meeting, with representatives from each of the 10 districts, to discuss lessons learned and advocacy strategies during the year.

Box 1: Civic Forum Highlights, Year 2

Serang District: FOPKIA helped put in place village-level regulations to encourage facility delivery, conducted an advocacy campaign, and partnered with DPRD to finalize local regulations on public services

Tegal & Banyumas Districts: KIBBLA conducted a blood donor drive (independent from direct support from EMAS) and developed village regulations on maternity savings and facility delivery.

Pinrang District: *Sayang Ibu dan Anak* persuaded hospitals to provide a complaint desk and manage feedback, conducted a blood drive (independent from direct support from EMAS) and took a lead in disseminating the results and recommendations of the CRC to DPRD and the MOH.

Cirebon District: KIBBLA influenced the 2014 budget and took a lead role in disseminating the CRC findings

EMAS has seen the capacity of the civic forums increase throughout the year, with some forums well on their way to operating at a high level and some still requiring additional support. To accelerate progress and prepare for working with Phase 2 civic forums, EMAS developed a set of guidelines for use in the next phase as well as a set of standardized criteria to objectively assess and monitor the "maturity" of civic forums. The standardized criteria define and assess the capacity of a civic forum across various factors that are believed to affect their effectiveness, such as their ability to self-finance, the level and extent of their external partnerships, as well as their ability to monitor services, organize communities and influence MNH policies. Civic forums assessed their own progress using the standards near the end of the year. Results from the assessment show that among the ten civic forums, the highest performing forums are in Serang, Banyumas, Bandung, Cirebon and Pinrang. Civic forums in Tegal, Deli Serdang, and Asahan are still in early stages

of development, while those in Malang and Sidoarjo are the least developed. Using the standardized criteria enables EMAS to better target support moving forward.

SIGAPKU

SIGAPKU, the Citizen Gateway, enables facilities to collect and respond to feedback from end users about the quality of care. At the beginning of the year, SIGAPKU was introduced to all 10 districts. The system was subsequently rolled out to all EMAS facilities in Quarters 2 – 4. All EMAS Phase 1 facilities are using the electronic feedback mechanism.

In addition to physically installing the system, throughout the year EMAS focused on supporting facility staff to fully take on the role of managing, distributing and responding to citizen feedback generated through SIGAPKU. For example, EMAS helped facilities implement standard operating procedures for managing feedback and ensured that the system was promoted to communities through MKIAs. Throughout the year, several hospitals rose as models of how to manage feedback, both through SIGAPKU and other mechanisms. For example, in Pinrang, RSUD Lasinrang and RS Siti Khadijah in addition to ten puskesmas have strong feedback management systems in place. Facilities in Tegal, Serang and Asahan have all taken steps to model their feedback management systems after those in Pinrang. The Pinrang systems will be used as a model for facilities added in Phase 2.

In total, feedback about facilities was sent 841 times in Year Two. However, currently EMAS has no practical option for determining the type or feedback received (eg. positive or negative, relevant to maternal/ newborn or other services). EMAS is exploring options for disaggregating feedback to enable more meaningful analyses in the future on using SIGAPKU as tool for improving systems of accountability.

Pokjas

In Year Two, Pokjas emerged as a key element of EMAS approaches. Pokjas are working groups comprised of influential actors who are capable of resolving issues from communities and finding solutions for supply-side barriers to service provision (policies, budgets, etc.). Pokjas are active in all EMAS districts, helping to resolve issues identified by facilities and to follow-up with community feedback.

Similar to civic forums, EMAS support to Pokjas in Year Two focused on strengthening the groups to become an effective means of solving identified challenges. While EMAS believes that Pokjas certainly have the ability to function as intended, it became clear throughout the year that most Pokjas were not reaching their full potential and that most did not proactively address issues as they arose. In recognition of this challenge, EMAS focused on strategies for improving the effectiveness of Pokjas. For example, some Pokjas included too large of a membership to be effective and were broken into smaller, more functional working groups. To systematically strengthen Pokjas, EMAS developed a set of performance indicators in Year Two that Pokjas can use to assess their progress and to identify key areas for additional support.

Despite challenges, several Pokjas have made notable achievements this year. For example, nearly all Pokjas have integrated maternal and newborn priorities into SKPD workplans and local budgets (RAPBD) for 2013 or 2014. In Pinrang, the Pokja supported the Bupati to issue a decree on maternal and newborn care. The same Pokja also initiated a cross-regional agreement with Kota Pare-Pare to better link on referral and MPAs. In Serang, the Pokja drafted an MOU with the PHO and facilities to better facilitate referrals and standard operating procedures to improve the process of managing feedback in the RSUD.

Box 2: What makes a high-functioning Pokja?

Legal Basis: Pokja is a legal entity with a written scope of work and objectives that are routinely followed

Composition: Pokja has an active and diverse membership including members from professional organizations, business, and community and civil society groups.

Regular Meetings: The Pokja holds regular meetings, both plenary and ad-hoc, routinely meets with health facilities, and regularly discusses MOU's service charters, mentoring, near miss and death audits and relevant policies

Budgetary and Workplan Influence: Incorporates feedback and recommendations into local budgets, workplans and decrees to address challenges in providing quality MNH services

Draft Policies: Supports drafting of policies and regulations relevant to maternal and newborn health

With technical support from EMAS, three pokjas completed their first performance assessments near the end of Quarter 4: Pinrang, Deli Serdang and Asahan. Of the three, Pinrang was found to be the highest performing, followed by Deli Serdang and Asahan. While each Pokja has areas that require improvement, all three have met enough criteria to begin mentoring others in Phase 2.

Citizen Report Cards

In Year Two, Citizen Report Cards (CRCs) were implemented by Civic Forums in Pinrang, Bandung, and Cirebon to help monitor health services. CRCs measure the perception of all aspects of care including access, quality, reliability, responsiveness and overall satisfaction with services. They serve as a feedback and accountability mechanism that can be used to both identify gaps in service provision and to hold providers accountable by identifying when providers have failed to deliver on the standard of service expected, such as delays in referral.

After the CRCs were conducted, Pinrang, Bandung and Cirebon districts disseminated the findings to key stakeholder groups in their districts, including the Bupati, the DHO/DINKES and health facilities. CRCs in these districts have been aligned with other EMAS accountability mechanisms, with findings and recommendations channeled to Pokjas and Civic Forums for monitoring and follow-up.

Early in the year, experience implementing the planned CRC approach in three districts and a review of the methodology for conducting the assessment highlighted challenges. EMAS, in collaboration with the USAID-funded Kinerja project, held a stakeholder meeting mid-year to review the CRC approach, where the original methodology was found to be too complex. In light of this, EMAS chose not to expand the use of CRCs in other districts. Instead, EMAS moved forward with identifying other approaches for collecting feedback in districts that had not already implemented CRCs. Two new approaches include Community Score Cards (CSCs) and the Collaborative Monitoring (CM) tool. These alternative approaches allow for greater flexibility and enable users to better adapt the methods according to their needs and capacity, while taking into account time constraints.

Sub-Objective 2.3: Financial barriers to access and utilization of services by the poor and vulnerable minimized

Increase citizen enrolment and utilization of Jampersal/Jamkesmas/Jamkesda

Analyses conducted in the first year of EMAS showed various barriers to utilizing social insurance schemes, such as *Jampersal*. EMAS took a two-pronged approached to overcoming these challenges in

Year Two that included working directly with pregnant women and communities as well as with health facilities.

Community-level outreach conducted during the year to increase use of *Jampersal* took the form of both information campaigns and one-on-one counseling. In collaboration with civic forums, EMAS identified *Motivator Kesehatan Ibu dan Anak* (MKIAs) to lead outreach efforts in communities and to counsel pregnant women to help them understand and encourage them to use *Jampersal*. Throughout the year, MKIAs played an important role in reaching pregnant women and served as a strong link between civic forums and the lowest levels of the community. In Year Two, EMAS focused on improving the knowledge of MKIAs to be able to assist pregnant women. MKIAs were oriented to high-risk pregnancies, the important of delivering in health facilities and details about using *Jampersal*. EMAS has seen MKIAs rise as a valuable tool for sharing information with civic forums, such as ensuring essential services like blood supplies are available.

In total, EMAS oriented 1154 MKIAs in Year Two. Through MKIAs, the program has been able to reach impressive numbers of pregnant women and communities. MKIAs worked one-on-one with over 1700 pregnant women and reached nearly 30,000 people through community-level events throughout the year.

In addition to working directly with users of social insurance, EMAS also focused on ensuring private hospitals were more knowledgeable about and able to accept Jampersal in Year Two. Throughout the year, facilities reported misunderstandings in how to both use and accept Jampersal. To address these challenges, EMAS focused on working directly with the heads of puskesmas as well as midwife coordinators.

Results show that these approaches are helping. The percentage of women using social insurance to cover the costs of birth in EMAS facilities has increased from 66 percent at Baseline to 87 percent in Year Two (Table 7). Increases have been seen in both private and public hospitals, as well as in puskesmas. Further, the percent of private EMAS facilities that participate in social insurance mechanisms increased from 40 percent at Baseline to 71 percent in Year Two.

Table 7: Percentage of women who deliver in EMAS facility that utilize a social insurance mechanism to cover the costs of the birth, Baseline vs. Year 2

Facility	Baseline (N=46,401)	Year Two (N=51,069)
Hospital, Private	21%	39 %
Hospital, Public	85 %	98 %
Puskesmas	60 %	96 %
Overall	66%	87%

Early in Year Two, the Indonesian government announced it would be rolling out universal health coverage *(Jaminan Kesehatan Nasional—JKN)* in January 2014 and therefore would no longer be signing new agreements with private hospitals to enable them to accept *Jampersal*. As JKN is rolled out during Year Three, EMAS will determine how it can best support the government and end-users through the life of the program.

VI. PROGRAM MANAGEMENT

Year Two marked the first year of actual program implementation for EMAS and with it, program management successes and challenges have arisen along the way. As a large and complex program with many staff, EMAS has had to regularly assess areas that work and those that present challenges in terms of effective management and staffing strategies. Program management highlights from the year are outlined below.

Staffing Changes and Organizational Structure

At the national-level, EMAS rolled out a new organizational structure for Jakarta-based staff to better align work flow and to ensure better integration among program components. The new structure is based on a functional team model and streamlines lines of supervision to facilitate better coordination across teams. In addition, several staffing changes occurred in Year Two at the national level.

- The expatriate Clinical Services Advisor resigned from her position early in the year. She was replaced in February 2013 by a US pediatrician.
- EMAS also added two additional expatriate staff, a Senior Strategic Information Advisor and a Senior Operations and Communications Advisor in January 2013.
- EMAS also made progress in building the capacity of the M&E, Communications and Business Development teams, adding an M&E Manager, a Communications Manager (as a replacement for a more junior Communications Officer), a Communications & Knowledge Management Coordinator, and Private Sector Manager (as a replacement) to help manage EMAS's cost share requirements.
- Late in the year, EMAS supported USAID in recruiting a Senior Maternal and Newborn Health Liaison. While this position was hired via the EMAS consortium, the position functions as USAID staff.
- Early in the year, EMAS identified the need for a new Jakarta-based position, a Senior Governance Advisor. EMAS actively recruited for this position and identified a possible candidate late in Quarter 4.

Finally, EMAS has sought to bring about additional efficiencies in the Jakarta office by carefully evaluating the function and workload of each position. As opportunities have arisen, EMAS has chosen to consolidate functions formerly divided among two or more positions. As a result, EMAS has a slightly leaner, but more effective team in Jakarta.

EMAS worked to streamline structures at the provincial level as well in Year Two. For example, a new structure was implemented in North Sumatra and Banten, in which the Provincial Team Leader position was redefined as a Senior Provincial Advisor. The change has clarified management responsibilities within the teams and enables the Senior Provincial Advisors to focus more on external relations. In preparation for expansion into Phase 2, extensive discussions took place with provincial teams to identify the most efficient staffing structures. EMAS has tried to balance the need for implementing the program over large geographic areas while avoiding adding too many staff or complicating team and supervision structures. The need to have high performing staff is even more important as the program moves into Phase 2. EMAS has chosen not to renew contracts of several staff this year due to performance to date. As with the Jakarta-based staff, EMAS has sought to identify efficiencies with staffing structures in the provinces, choosing not to fill some positions as they become vacant. Recruitment is currently underway for Phase 2. Finally, as part of a set of changes to improve data quality within the program, EMAS modified the supervisory lines for provincial based M&E Officers. The M&E Officers report directly to the Jakarta-based M&E Director rather than the Provincial Team Leaders.

Aligning Implementation Approaches and Workplanning

Ensuring all EMAS staff across six provinces have a clear understanding of how to implement program approaches can be challenging. Early in the year, EMAS visited each province to clarify the process of program implementation and the roles and responsibilities of each team member. In addition, to ensure a unified approach for Phase 2, EMAS held a week-long workplanning retreat in Bandung. The retreat was structured to enable EMAS to take stock of progress made thus far and lessons learned, as well as to define the most effective strategies for moving forward. Two days of the retreat were dedicated to in-depth discussions about EMAS approaches and key activities for Year Three. Yet, EMAS still has an ongoing need to strengthen teamwork across provincial and national teams. Year Two was marked by an intense focus on the initial roll out of individual components of such a large program. Although there is a huge scope of work ahead, EMAS is hopeful that with the majority of the details of activity implementation are now well understood, that more traction can be made in cross-functional teamwork.

Strengthening Management Systems

Throughout the year, EMAS has focused on streamlining and strengthening management systems. Strategies and processes to improve the consistency and quality of reporting and program monitoring as well as ways to improve collaboration and decision-making across teams have all been put in place. While many of these changes will take time before the full effects are seen, there is initial evidence that these, along with other changes in organizational structures and lines of supervision, have had a positive impact on the program.

While EMAS believes that program management is becoming more effective, EMAS is also aware that management systems can continue to be strengthened. In Year Two, EMAS identified an external management consultant that will identify and lead sessions for EMAS staff on improving management effectiveness. The consultant will begin working with EMAS in Year 3.

VII. M&E

EMAS carried our several activities designed to strengthen routine monitoring practices and data quality in Year Two. Work began on an online data management platform to manage the large amounts of data generated by the program, a data quality assessment was conducted to target specific areas for data quality improvement, and standardized tools such as standard registers and standard operating procedures were introduced. A detailed review of these activities is provided below.

Online Data Management System

An online database management system was developed in Year Two to support the decentralized M&E team and facilitate province-level data entry. The system is designed to match the nine data entry forms used by EMAS for PMP data collection. Logic checks have been built into the system to minimize data entry errors and simple reports have been incorporated to allow easier access to and use of monitoring data by EMAS team members.

Roll out of the system was originally planned for Quarter 3, but changes to the EMAS PMP resulted in delays. The system is expected to be ready for field testing and data entry early in Year Three.

Routine Data Quality Assessment (RDQA)

In January 2013, a data quality assessment was conducted. M&E officers were oriented to the MEASURE-developed routine data quality assessment (RDQA) tool, which was used to examine data quality for a select number of facility-based indicators for a sample of facilities in their respective provinces. Assessments were conducted in 11 puskesmas and six hospitals.

EMAS identified both internal and external challenges related to data quality through the RDQA process. External challenges were related to the current health facility recording practice, while internal challenges centered around the lack of standardized data collection practices by the EMAS M&E team. Plans to address both sets of challenges were developed including the development of standard operating procedures for data collection practices as well as the development and introduction of standard registers in the EMAS facilities.

Introduction of Standard Registers

Individual health facilities developed hand-written registers to record patient information. Registers varied in the data elements tracked and the method by which they were tracked. To improve data quality and assist with facility data management practices, EMAS developed standard registers. Four registers were developed for hospitals: maternal, perinatal, maternal death and perinatal death. EMAS also developed three registers for puskesmas: maternity-newborn, maternal death, and perinatal death registers. A monthly summary form was developed for the maternal, perinatal and maternal newborn registers to assist with routine data reporting requirements for the MOH and also for dashboard indicators.

The registers were piloted in 11 facilities (7 puskesmas and 4 hospitals, including Budi Kemuliaan) in Quarter Two of this year. Following the pilot, a training-of-trainers was held with M&E Officers to orient them to the registers. The M&E Officers in turn oriented their respective EMAS teams, district health offices and facilities. By August 2013, the standard registers were distributed and in use by the majority of EMAS-supported facilities (97 of 116). Data use trainings planned in Year Three will emphasize the utility of reliable and complete facility recording practices.

Standard Operating Procedures

Standard operating procedures (SOPs) were drafted to standardize data collection practices across EMAS in Year Two. The SOPs provide detailed instructions for the nine data collection forms used by the M&E team. Additionally, the SOPs outline reporting deadlines, the flow of information, and explain the roles and responsibilities of individuals who support PMP data collection. The SOPs will be finalized in the first quarter of year 3.

VIII. IMPLEMENTATION CHALLENGES/ISSUES

Over the last year of program implementation, EMAS has faced several implementation challenges. While EMAS has been able to overcome many of these obstacles with adjustments to strategies and approaches along the way, many of the challenges faced are a result of implementing a complex and large-reaching program that at its core seeks to affect long-term changes in behavior and practice. Affecting such changes requires time and often, one-size fits all approaches are less effective in making headway in these areas.

Yet, EMAS believes that the fundamental approaches used as part of the program will bring about the types of changes required to make lasting a lasting impact on maternal and newborn outcomes. As discussed in previous sections in this report, EMAS has proactively sought to address implementation challenges as they arise and has modified approaches as needed throughout the year to overcome these issues. Still, EMAS recognizes that additional support from the program may be needed in several areas to be fully effective moving forward.

Program Management and Staffing

The size and scope of the EMAS program, combined with an aggressive timeline for expansion presents challenges for even the best managed organizations. Managing staffing, ensuring a shared vision and strategy across all staff and putting in place effective and comprehensive, yet nimble systems requires substantial time and effort for a program of this magnitude. While EMAS has made significant improvements over the last year in terms of overall program management, there is also recognition that more can be done to improve the overall efficiency and effectiveness of program operations. Expanding the Phase 2 districts and cities presents a real staffing challenge. Not only must EMAS oversee a large recruitment and orientation effort at one-time, it will also need to maintain a presence in Phase 1 districts to ensure progress is sustained. A balance between efficient, yet adequate staffing levels must be met in Year Three. The leadership of EMAS is well aware of the challenges that lie ahead and have taken several steps to improve overall management, including working with an external management consultant to provide guidance in this area.

Data Monitoring and Quality

Collecting data from 116 health facilities and across program activities in ten districts has been a challenge in Year Two. Standardized clinical data recording is not routinely practiced in Indonesia. This has presented a huge challenge for being able to collect quality data on time from health facilities. This challenge has been compounded by areas of internal weaknesses that were recognized early on in Year Two as well as turnover of M&E staff in the field. EMAS takes these challenges seriously and has implemented several strategies to improve data quality such as by bringing in additional M&E expertise, implementing standard operating procedures, and developing an M&E database to more effectively and efficiency manage the large amounts of program data. EMAS also rolled out standardized registers to EMAS facilities late in Year Two which are expected to have a significant impact on data quality moving forward.

Facility Mentoring

EMAS did not anticipate that all 23 Phase 1 hospitals would be ready to mentor by the end of Year 2; nevertheless, impacting quality within a core group of hospitals has been much more resource intensive than anticipated at the beginning of the year. While EMAS expects 16 hospitals to take on a mentoring role in Phase 2, not all 16 are expected to be ready at the start of Phase 2 roll out. Throughout the year, EMAS has had to add additional mentoring visits to several facilities to boost mentoring readiness, which in turn pushed back the P4 visits. In addition, EMAS recognizes that it will need to remain involved at some level in mentoring Vanguard facilities in Phase 2. While support will be expected to wane over the course of the year, this added mentoring burden will have a significant impact on human resources, management and logistics. EMAS has developed new strategies to add supplementary mentoring resources in Year Three, such as the use of teaching hospitals and influential Muhammadiyah hospitals, capacity building of internal EMAS clinical mentors, and using US-based volunteer physicians.

Clinical Governance Systems

As discussed previously, EMAS knows that effective clinical governance systems take time to foster. Throughout the year EMAS has seen successes and shortcomings in how well these systems have been adopted and accepted in facilities. With the overall impact of these systems not likely to be seen for several years in some cases, EMAS has recognized that it needs to implement complementary measures to make faster, high-impact changes in the quality of care. EMAS has developed several strategies to overcome this reality, including designing and getting buy-in on decision support tools which will be rolled out in Year Three.

Accountability and Governance

Strengthening governance and accountability interventions has been a key focus in Year Two. Pokjas, seen as a critical component of the overall EMAS approach, have not reached their full potential as an influential group capable of addressing issues as they arise. In Year Two, few Pokjas were found to proactively solve problems and too few people used Pokjas to address identified issues. EMAS believes that Pokjas poses the ability to function as required, but recognizes that additional inputs will be necessary to move to a model where Pokja actions are internally driven, rather that largely driven by EMAS. EMAS has recently developed standardized criteria by which Pokjas can assess their strengths and identify weaknesses, which, combined with additional support from EMAS is hoped to help move Pokjas down a path towards being more effective.

Other accountability mechanisms implemented under EMAS have also been found to be slow to take effect. EMAS recognizes that efforts need to continue to ensure more involvement from citizens to hold facilities accountable for quality services. Overall, the concept of feedback and accountability mechanisms for improving the quality of care is still relatively new. EMAS is currently exploring ways to accelerate progress in these areas.

Referral Systems:

As noted above, ensuring that districts conduct an audit of all maternal deaths and 15 percent of neonatal deaths has been challenging. In some cases, districts are not yet convinced that audits are critically important to identifying gaps. In other cases, districts are carrying out audits, but the process lacks objectivity and does not necessarily lead to meaningful and timely solutions. As the MOH becomes increasingly interested in audits, mandates from MOH may lead to more frequent audits. However, the process itself may remain ineffective at impacting change. EMAS is actively nurturing "champion" districts to serve as models for other districts. Year Three and Year Four activities may require more intensive external assistance to Indonesia from countries that have implemented successful approaches.

IX. COST SHARE

EMAS has made significant progress towards meeting cost share requirements in Year Two. A combination of strategies have been used to do this, including seeking cash and in-kind contributions from local government, partners, and corporations to directly support EMAS activities as well as seeking funding for activities that contribute to EMAS objectives.

Throughout the year, EMAS focused on putting in place systems to better identify, document and report cost share. At the end of Year Two, EMAS had a total of $5.9 million in actual and committed cost share

and an additional $1.9 million of identified potential cost share. Annex 3 provides a detailed breakdown of cost share to date.

LIST OF ANNEXES

ANNEX 1: EMAS PMP, BASELINE, YEAR ONE AND YEAR TWO

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
			%	Num	Den	%	Num	Den	%	Num	Den
Objective 1: Improved quality of emergency obstetric and neonatal care services in hospitals and community health centers											
Result 1.1: High impact, life-saving clinical interventions are implemented in hospitals and community health centers											
1	**Obstetric case fatality rate (CFR)**		**1.6%**	57	3,579				**1.6%**	84	5,181
2	**Fresh stillbirth and very early neonatal death rate**		not available						**1.8%**	867	47,179
3	**% of EMAS facilities that achieve 100% of EmONC standards (includes indicators #14, #18 and #19)**	*(1) hospital maternal standard*	**NA**			**0%**	0	23	**4%**	1	23
		(2) hospital newborn	**NA**			**0%**	0	23	**13%**	3	23
		(3) hospital IP	**NA**			**NA**			**13%**	3	23
		(4) hospital clinical governance	**NA**			**NA**			**13%**	3	23
		(5) puskesmas MNH	**NA**			**0%**	0	93	**10%**	9	93
		(6) puskesmas IP	**NA**			**NA**			**6%**	5	93
	Hospitals										
3a	*Hospital performance for maternal standards*	*(1) achieve < 50%*	**NA**			**100%**	23	23	**0%**	0	23
		(2) achieve 50-79%	**NA**			**0%**	0	23	**35%**	8	23
		(3) achieve 80 to 100%	**NA**			**0%**	0	23	**65%**	15	23
3b	*Hospital performance for newborn standards*	*(1) achieve < 50%*	**NA**			**100%**	23	23	**0%**	0	23
		(2) achieve 50-79%	**NA**			**0%**	0	23	**35%**	8	23
		(3) achieve 80 to 100%	**NA**			**0%**	0	23	**65%**	15	23

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
3bi	*Performance for KMC (included within neonatal standards)*	*(1) achieve < 50%*	**NA**			**83%**	19	23	**9%**	2	23
		(2) achieve 50-79%	**NA**			**17%**	4	23	**13%**	3	23
		(3) achieve 80 to 100%	**NA**			**0%**	0	23	**78%**	18	23
3c	*Hospital performance for infection prevention standards*	*(1) achieve < 50%*	**NA**			**NA**			**9%**	2	23
		(2) achieve 50-79%	**NA**			**NA**			**13%**	3	23
		(3) achieve 80 to 100%	**NA**			**NA**			**78%**	18	23
3d	*Hospital performance for clinical governance standards*	*(1) achieve < 50%*	**NA**			**NA**			**39%**	9	23
		(2) achieve 50-79%	**NA**			**NA**			**43%**	10	23
		(3) achieve 80 to 100%	**NA**			**NA**			**17%**	4	23
	Puskesmas										
3e	*Puskesmas performance for maternal & newborn standards*	*(1) achieve < 50%*	**NA**			**100%**	93	93	**17%**	16	93
		(2) achieve 50-79%	**NA**			**0%**	0	93	**41%**	38	93
		(3) achieve 80 to 100%	**NA**			**0%**	0	93	**42%**	39	93
3f	*Puskesmas performance for infection prevention standards*	*(1) achieve < 50%*	**NA**			**NA**			**11%**	10	87
		(2) achieve 50-79%	**NA**			**NA**			**28%**	24	87
		(3) achieve 80 to 100%	**NA**			**NA**			**61%**	53	87
4	**% of cases of severe pre-eclampsia/eclampsia managed with magnesium sulfate (MgSO4) according to global standards at EMAS facilities**	***overall***	**80%**	2,767	3,467	**90%**	1,012	1,123	**86%**	4,131	4,824
		Hospital, private	**97%**	252	260	**97%**	82	91	**91%**	381	417
		Hospital, public	**78%**	2,515	3,207	**90%**	924	1,032	**85%**	3,195	3,777
		Puskesmas	**NA**	NA	NA	**NA**			**88%**	555	630
5	**% of EMAS facilities that conduct death audits on <u>all</u> fresh stillbirths > 2000 grams**	***overall***	**2%**	2	116	**3%**	3	116	**3%**	3	116

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
		no stillbirths > 2000 g reported	**0%**	0	12	**58%**	7	12	**83%**	10	12
	Hospital, private	*(1) < 50% of stillbirths audited*	**100%**	12	12	**42%**	5	12	**17%**	2	12
		(2) 50-79% of stillbirths audited	**0%**	0	12	**0%**	0	12	**0%**	0	12
		(3) 80 to 100% of stillbirths audited	**0%**	0	12	**0%**	0	12	**0%**	0	12
		no stillbirths > 2000 g reported	**9%**	1	11	**27%**	3	11	**45%**	5	11
	Hospital, public	*(1) < 50% of stillbirths audited*	**91%**	10	11	**55%**	6	11	**36%**	4	11
		(2) 50-79% of stillbirths audited	**0%**	0	11	**9%**	1	11	**0%**	0	11
		(3) 80 to 100% of stillbirths audited	**0%**	0	11	**9%**	1	11	**18%**	2	11
		no stillbirths > 2000 g reported	**87%**	81	93	**95%**	88	93	**98%**	91	93
	Puskesmas	*(1) < 50% of stillbirths audited*	**6%**	6	93	**3%**	3	93	**1%**	1	93
		(2) 50-79% of stillbirths audited	**4%**	4	93	**0%**	0	93	**0%**	0	93
		(3) 80 to 100% of stillbirths audited	**2%**	2	93	**2%**	2	93	**1%**	1	93
6	**% of EMAS facilities that conduct death audits on <u>all</u> neonatal deaths > 2000 grams**	***overall***	**3%**	4	116	**2%**	2	116	**6%**	7	116

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
		no neonatal deaths > 2000 g	**8%**	1	12	**33%**	4	12	**25%**	3	12
		(1) < 50% of deaths audited	**92%**	11	12	**50%**	6	12	**42%**	5	12
	Hospital, private	*(2) 50-79% of deaths audited*	**0%**	0	12	**17%**	2	12	**17%**	2	12
		(3) 80 to 100% of deaths audited	**0%**	0	12	**0%**	0	12	**17%**	2	12
		no neonatal deaths > 2000 g	**36%**	4	11	**0%**	0	11	**0%**	0	11
		(1) < 50% of deaths audited	**55%**	6	11	**91%**	10	11	**55%**	6	11
	Hospital, public	*(2) 50-79% of deaths audited*	**0%**	0	11	**0%**	0	11	**9%**	1	11
		(3) 80 to 100% of deaths audited	**9%**	1	11	**9%**	1	11	**36%**	4	11
		no neonatal deaths > 2000 g	**88%**	82	93	**97%**	90	93	**99%**	92	93
		(1) < 50% of deaths audited	**8%**	7	93	**2%**	2	93	**1%**	1	93
	Puskesmas	*(2) 50-79% of deaths audited*	**0%**	0	93	**0%**	0	93	**0%**	0	93
		(3) 80 to 100% of deaths audited	**4%**	4	93	**1%**	1	93	**0%**	0	93
7	**% of EMAS facilities that conduct death audits on <u>all</u> maternal deaths**	***overall***	**5%**	6	116	**3%**	3	116	**7%**	8	116
		no maternal deaths reported	**58%**	7	12	**67%**	8	12	**50%**	6	12
		(1) < 50% of deaths audited	**25%**	3	12	**33%**	4	12	**17%**	2	12
	Hospital, private	*(2) 50-79% of deaths audited*	**0%**	0	12	**0%**	0	12	**0%**	0	12
		(3) 80 to 100% of deaths audited	**17%**	2	12	**0%**	0	12	**33%**	4	12

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
		no maternal deaths reported	**0%**	0	11	**27%**	3	11	**18%**	2	11
		(1) < 50% of deaths audited	**82%**	9	11	**55%**	6	11	**45%**	5	11
	Hospital, public	*(2) 50-79% of deaths audited*	**0%**	0	11	**0%**	0	11	**0%**	0	11
		(3) 80 to 100% of deaths audited	**18%**	2	11	**18%**	2	11	**36%**	4	11
		no maternal deaths reported	**95%**	88	93	**98%**	91	93	**99%**	92	93
		(1) < 50% of deaths audited	**2%**	2	93	**1%**	1	93	**0%**	0	93
	Puskesmas	*(2) 50-79% of deaths audited*	**0%**	0	93	**0%**	0	93	**0%**	0	93
		(3) 80 to 100% of deaths audited	**3%**	3	93	**1%**	1	93	**1%**	1	93
8	**% of EMAS hospitals that conduct regularly scheduled near miss audits**	***overall***	**13%**	3	23	**9%**	2	23	**43%**	10	23
		Hospitals, private	**0%**	0	12	**8%**	1	12	**25%**	3	12
		Hospitals, public	**27%**	3	11	**9%**	1	11	**64%**	7	11
9	**% of deliveries that receive at least one dose of uterotonic postpartum during third stage of labor at EMAS facilities**	***overall***	**82%**	38,058	46,401	**71%**	9,882	13,180	**92%**	46,811	51,069
		Hospital, private	**57%**	4,791	8,400	**60%**	1,372	2,292	**86%**	7,786	9,030
		Hospital, public	**85%**	20,889	24,548	**73%**	5,709	7,816	**93%**	28,447	30,739
		Puskesmas	**92%**	12,378	13,453	**91%**	2,801	3,072	**94%**	10,578	11,300

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
10	**Proportion of newborns delivered in EMAS hospitals at < 36 weeks of gestation who have received antenatal steroids within 5 days of birth**	***overall***	**28%**	1,715	6,206	**25%**	613	2,413	**35%**	1,865	5,344
11	**% of live births who are breastfed within 1 hour of birth at EMAS facilities**	***overall***	**36%**	15,997	43,898	**37%**	4,594	12,533	**51%**	25,333	49,537
		Hospital, private	**16%**	1,261	8,124	**22%**	487	2,237	**45%**	4,031	9,058
		Hospital, public	**21%**	4,790	22,508	**22%**	1,661	7,435	**39%**	11,452	29,314
		Puskesmas	**75%**	9,946	13,266	**85%**	2,446	2,861	**88%**	9,850	11,165
12	**% of EMAS facilities with system in place to refresh competency in basic neonatal resuscitation skills for healthcare providers**	***overall***	**9%**	11	116	**32%**	37	116	**46%**	53	116
		Hospital, private	**17%**	2	12	**50%**	6	12	**58%**	7	12
		Hospital, public	**45%**	5	11	**45%**	5	11	**73%**	8	11
		Puskesmas	**4%**	4	93	**28%**	26	93	**41%**	38	93
13	**% of EMAS facilities with dedicated space for mothers to practice Kangaroo Mother Care (KMC), written standard operating procedure (SOP) that requires provision of Kangaroo Mother Care to all medically stable neonates between 1000 to 2000 grams, and staff trained in KMC**	***overall***	**13%**	3	23	**30%**	7	23	**57%**	13	23
		Hospital, private	**0%**	0	12	**17%**	2	12	**17%**	2	12
		Hospital, public	**27%**	3	11	**45%**	5	11	**73%**	8	11
14	**Number of health facilities that meet 100% of performance standards for KMC**										
	(captured in PMP indicator #3)										

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
15	**Number of calls made from providers in EMAS facilities to an emergency obstetric and neonatal care hotline**										
	(indicator not used since hotline not implemented)										
16	**% of correct responses to SMS provider support quizzes sent to providers**	***overall***	**NA**			**NA**			**89%**	3,551	4,009
		Banten	**NA**			**NA**			**89%**	722	815
		Central Java	**NA**			**NA**			**93%**	427	458
		East Java	**NA**			**NA**			**85%**	318	372
		North Sumatra	**NA**			**NA**			**88%**	105	120
		South Sulawesi	**NA**			**NA**			**84%**	288	344
		West Java	**NA**			**NA**			**89%**	1,691	1,900
17	**% of SMS recipients who respond to quizzes**	***overall***	**NA**			**NA**			**26%**	4,009	15,454
		Banten	**NA**			**NA**			**39%**	815	2,093
		Central Java	**NA**			**NA**			**17%**	458	2,717
		East Java	**NA**			**NA**			**22%**	372	1,664
		North Sumatra	**NA**			**NA**			**9%**	120	1,265
		South Sulawesi	**NA**			**NA**			**26%**	4,009	15,454
		West Java	**NA**			**NA**			**34%**	1,900	5,537
Result 1.2: Strong clinical governance practices established in hospitals and community health centers											
18	**% of EMAS facilities that achieve 100% of EmONC standards for maternal care**										
	(captured in PMP indicator #3)										

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
19	**% of EMAS facilities that achieve 100% of EmONC standards for newborn care**										
	(captured in PMP indicator #3)										
20	**% of EMAS facilities with a mechanism in place to receive, process, and respond to patient feedback**	***overall***	**NA**			**NA**			**11%**	13	116
		Hospital, private	**NA**			**NA**			**0%**	0	12
		Hospital, public	**NA**			**NA**			**82%**	9	11
		Puskesmas	**NA**			**NA**			**4%**	4	93
Objective 2:Increased efficiency and effectiveness of referral system between community and hospitals											
Result 2.1:Referral system strengthened and functioning optimally											
21	**Referral standards developed with EMAS assistance adopted by MOH**		**NA**			0			0		
22	**% of EMAS referral networks achieving 100% of referral performance standards**	***overall***	**NA**			**NA**			**0%**	0	10
	Latest district-specific scores	*Asahan*	**NA**			**NA**			65%		
		Bandung	**NA**			**NA**			75%		
		Banyumas	**NA**			**NA**			66%		
		Cirebon	**NA**			**NA**			94%		
		Deli Serdang	**NA**			**NA**			55%		
		Malang	**NA**			**NA**			83%		
		Pinrang	**NA**			**NA**			85%		
		Serang	**NA**			**NA**			86%		
		Sidoarjo	**NA**			**NA**			73%		
		Tegal	**NA**			**NA**			78%		

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
23	**% of women with severe pre-eclampsia/eclampsia (PE/E) who are referred to EMAS hospitals from puskesmas/clinics and who receive at least one correct dose of magnesium sulfate (MgSO4) before referral**	***overall***	**21%**	589	2,839	**22%**	212	968	**25%**	811	3,293
		Hospital, private	**0%**	0	159	**0%**	0	61	**9%**	26	292
		Hospital, public	**22%**	589	2,680	**23%**	212	907	**26%**	785	3,001
24	**% of newborns with suspected severe infection who are referred to EMAS hospitals from puskesmas/clinics and who receive at least one does of antibiotics per national guidelines before referral**	***overall***	**18%**	334	1,878	**28%**	120	424	**14%**	149	1,085
		Hospital, private	**45%**	76	170	**38%**	11	29	**47%**	96	205
		Hospital, public	**15%**	258	1,708	**28%**	109	395	**6%**	53	880
25	**# of referral exchange messages in EMAS referral networks**	***overall***	**NA**			**NA**			**6,717**		
	(Value represents the # of unique referral cases managed by SijariEMAS)	*Calls*	**NA**			**NA**			**189**		
		Messages	**NA**			**NA**			**6,528**		
26	**% of all reported maternal and perinatal deaths audited using the Maternal Perinatal Audit (MPA) process in EMAS districts**	*maternal*	**NA**			**NA**			**27%**	90	338
		neonatal	**NA**			**NA**			**11%**	227	1,977
	Asahan	*maternal*	**NA**			**NA**			**67%**	8	12
		neonatal	**NA**			**NA**			**45%**	72	161
	Bandung	*maternal*	**NA**			**NA**			**7%**	2	28
		neonatal	**NA**			**NA**			**2%**	2	81

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
	Banyumas	*maternal*	**NA**			**NA**			**64%**	38	59
		neonatal	**NA**			**NA**			**12%**	42	363
	Cirebon	*maternal*	**NA**			**NA**			**5%**	2	44
		neonatal	**NA**			**NA**			**1%**	2	183
	Deli Serdang	*maternal*	**NA**			**NA**			**0%**	0	6
		neonatal	**NA**			**NA**			**0%**	0	31
	Malang	*maternal*	**NA**			**NA**			**26%**	9	34
		neonatal	**NA**			**NA**			**16%**	40	247
	Pinrang	*maternal*	**NA**			**NA**			**40%**	4	10
		neonatal	**NA**			**NA**			**50%**	34	68
	Serang	*maternal*	**NA**			**NA**			**4%**	2	46
		neonatal	**NA**			**NA**			**2%**	4	245
	Sidoarjo	*maternal*	**NA**			**NA**			**27%**	7	26
		neonatal	**NA**			**NA**			**2%**	7	289
	Tegal	*maternal*	**NA**			**NA**			**25%**	18	73
		neonatal	**NA**			**NA**			**8%**	24	299
Result 2.2: Citizens and CSOs holding providers, facilities and local government accountable for quality services and efficient referral systems											
27	**% of EMAS districts implementing MNH citizen report cards per the designated schedule**		**NA**			**NA**			**30%**	3	10
		Asahan	**NA**			**NA**			**0**	0	1
		Bandung	**NA**			**NA**			**100%**	1	1
		Banyumas	**NA**			**NA**			**0%**	0	1
		Cirebon	**NA**			**NA**			**100%**	1	1

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
		Deli Serdang	**NA**			**NA**			**0%**	0	1
		Malang	**NA**			**NA**			**0%**	0	1
		Pinrang	**NA**			**NA**			**100%**	1	1
		Serang	**NA**			**NA**			**0%**	0	1
		Sidoarjo	**NA**			**NA**			**0%**	0	1
		Tegal	**NA**			**NA**			**0%**	0	1
28	**% of complaints/suggestions received through EMAS supported feedback mechanisms, which are documented as resolved by local governments or public service delivery units**	***overall***	**NA**			**NA**			**15%**	203	1,369
		Asahan	**NA**			**NA**			**26%**	12	46
		Bandung	**NA**			**NA**			**55%**	35	64
		Banyumas	**NA**			**NA**			**36%**	72	202
		Cirebon	**NA**			**NA**			**0%**	2	627
		Deli Serdang	**NA**			**NA**			**52%**	32	61
		Malang	**NA**			**NA**			**10%**	6	62
		Pinrang	**NA**			**NA**			**6%**	3	51
		Serang	**NA**			**NA**			**6%**	2	36
		Sidoarjo	**NA**			**NA**			**20%**	11	55
		Tegal	**NA**			**NA**			**17%**	28	165
29	**% of EMAS target facilities that sign a service charter with community**	***overall***	**NA**			**NA**			**100%**	116	116
		Hospital, private	**NA**			**NA**			**100%**	12	12
		Hospital, public	**NA**			**NA**			**100%**	11	11
		Puskesmas	**NA**			**NA**			**100%**	93	93
Result 2.3: Financial barriers to access and utilization of services by the poor and vulnerable minimized											

#	PERFORMANCE INDICATOR	*DISAGGREGATION CATEGORIES*	New Baseline (January - December 2011)			Year 1 July - September 2012			Year 2 October 2012 - September 2013		
30	**% of women who deliver in EMAS facilities and who utilize a social insurance mechanism to cover the costs of the birth**	***overall***	**66%**	30,656	46,401	**89%**	11,762	13,180	**87%**	44,555	51,069
		Hospital, private	**21%**	1,769	8,400	**22%**	493	2,292	**39%**	3,521	9,030
		Hospital, public	**85%**	20,804	24,548	**108%**[2]	8,432	7,816	**98%**	30,192	30,739
		Puskesmas	**60%**	8,083	13,453	**92%**	2,837	3,072	**96%**	10,842	11,300
31	**% of private facilities participating in social insurance mechanisms in EMAS vanguard networks**		**40%**	6	14	**21%**	3	14	**71%**	10	14
	(as MOUs with private facilities for Jampersal were discontinued effective January 1, 2013, this indicator will no longer be tracked)										

[2] Because social insurance mechanisms available to pregnant women are not mutually exclusive, the value exceeds 100 %

ANNEX 2: VANGUARD READINESS TABLES & PERFORMANCE STANDARD ACHIEVEMENT (CLINICAL & REFERRAL STANDARDS)

Table 1: Vanguard Network Readiness Summary

Network	Clinical Performance results	Service Charter	Perjanjian Kerjasama (MOU)	Pokja	Civic Forum	SijariEMAS (Referral ICT)	Sigapku (Citizen feedback, ICT)	SIPPP (Learning and Performance Reinforcement)	Referral Standards
Asahan	(2 hospitals)	100%	100%	Yes	Yes	100%	100%	100%	65%
Deli Serdang	(4 hospitals)	100%	100%	Yes	Yes	100%	100%	100%	55%
Serang	(1 hospital)	100%	100%	Yes	Yes	100%	100%	100%	86%
Bandung	(1 hospital)	100%	100%	Yes	Yes	100%	100%	100%	75%
Cirebon	(1 hospital)	100%	100%	Yes	Yes	100%	100%	100%	94%
Banyumas	(2 hospitals)	100%	100%	Yes	Yes	100%	100%	100%	66%
Tegal	(2 hospitals)	100%	100%	Yes	Yes	100%	100%	100%	78%
Malang	(4 hospitals)	100%	100%	Yes	Yes	100%	100%	100%	83%
Sidoarjo	(3 hospitals)	100%	100%	Yes	Yes	100%	100%	100%	73%
Pinrang	(2 hospitals)	100%	100%	Yes	Yes	100%	100%	100%	85%

Key:	0 to 24%	25-49%	50-79%	80-100%

Table 2: District Vanguard Network Readiness, by facility

Vanguard Network	Assessment #	Performance Standards: Maternal	Newborn	Infection Prevention	Governance	Service Charter	Perjanjian Kerjasama (MOU)	Pokja (wrk group)	Civic Forum	SijariEMAS (referral ICT)	Sigapku (citizen feedback, ICT)	SIPPP (Learning and Performance Reinforcement)	Referral Standards
ASAHAN						100%	100%	yes	yes	100%	100%	100%	65%
RSUD Abdul Manan Simatupang	A4	87	62	68	80	yes	yes	Per District	Per District	yes	yes	yes	61%
RS Ibu Kartini	A4	65	53	47	0	yes	yes			yes	yes	yes	50%
PKM Tinggi Raja	A3	44		94		yes	yes			yes	yes	yes	56%
PKM Rawang Pasar IV	A3	44		27		yes	yes			yes	yes	yes	50%
PKM Aek Songsongan	A4	74		67		yes	yes			yes	yes	yes	81%
PKM Binjai Serbangan	A3	79		13		yes	yes			yes	yes	yes	69%
PKM Simpang Empat	A3	84		50		yes	yes			yes	yes	yes	75%
PKM Pulau Rakyat	A3	61		88		yes	yes			yes	yes	yes	63%
PKM Bandar Pasir Mandoge	A4	84		88		yes	yes			yes	yes	yes	88%
PKM Meranti	A4	78		100		yes	yes			yes	yes	yes	63%
DELISERDANG						100%	100%	yes	yes	100.0%	100.0%	100.0%	55%
RSUD Deli Serdang	A4	97	87	93	0	yes	yes	Per District	Per District	yes	yes	yes	72%
RS Muhammadiyah Medan	A4	79	76	90	40	yes	yes			no	no	yes	33%
RS Sembiring	A4	66	68	40	33	yes	yes			no	no	yes	39%
RS Haji	A4	69	79	86	0	yes	yes			no	no	yes	61%
PKM Bangun Purba	A3	89		94		yes	yes			yes	yes	yes	41%

	Performance Standards												
Vanguard Network	**Assessment #**	**Maternal**	**Newborn**	**Infection Prevention**	**Governance**	**Service Charter**	**Perjanjian Kerjasama** (MOU)	**Pokja (wrk group)**	**Civic Forum**	**SijariEMAS** (referral ICT)	**Sigapku** (citizen feedback, ICT)	**SIPPP** (Learning and Performance Reinforcement)	**Referral Standards**
PKM Tiga Juhar	A3	28		44		yes	yes			yes	yes	yes	47%
PKM Sibiru-Biru	A3	78		67		yes	yes			yes	yes	yes	65%
PKM Namorambe	A3	58		25		yes	yes			yes	yes	yes	29%
PKM Pantai Labu	A3	72		63		yes	yes			yes	yes	yes	24%
PKM Talun Kenas	A4	89		94		yes	yes			yes	yes	yes	88%
PKM Tanjung Morawa	A2	16		0		yes	yes			yes	yes	yes	53%
PKM Batang Kuis	A3	79		80		yes	yes			yes	yes	yes	53%
PKM Aras Kabu	A4	83		100		yes	yes			yes	yes	yes	88%
PKM Bandar Khalifah	A3	47		94		yes	yes			yes	yes	yes	76%
SERANG						100%	100%	yes	yes	100.0%	100.0%	100.0%	86%
RSUD SERANG	A4	82	76	100	67	yes	yes	Perdistrict	Perdistrict	yes	yes	yes	72%
PKM Kramatwatu	A3	79		94		yes	yes			yes	yes	yes	76%
PKM PAMARAYAN	A3	89		94		yes	yes			yes	yes	yes	88%
PKM Petir	A3	42		69		yes	yes			yes	yes	yes	94%
PKM Cikande	A2	67		40		yes	yes			yes	yes	yes	76%
PKM Anyer	A2	39		80		yes	yes			yes	yes	yes	82%
PKM Cikeusal	A2	39		21		yes	yes			yes	yes	yes	88%

	Performance Standards													
Vanguard Network	**Assessment #**	**Maternal**	**Newborn**	**Infection Prevention**	**Governance**	**Service Charter**	**Perjanjian Kerjasama** (MOU)	**Pokja (wrk group)**	**Civic Forum**	**SijariEMAS** (referral ICT)	**Sigapku** (citizen feedback, ICT)	**SIPPP** (Learning and Performance Reinforcement)	**Referral Standards**
PKM Kraglian	A3	56		56		yes	yes			yes	yes	yes	94%
PKM Ciomas	A2	94		88		yes	yes			yes	yes	yes	100%
PKM Pontang	A3	89		94		yes	yes			yes	yes	yes	88%
PKM Bojonegara	A2	67		100		yes	yes			yes	yes	yes	88%
BANDUNG						100%	100%	yes	yes	100.0%	100.0%	100.0%	75%
RSUD Majalaya	A5	92	85	95	50	yes	yes	Per District	Per District	yes	yes	yes	78%
PKM Ciparay	A5	84		71		yes	yes			yes	yes	yes	100%
PKM Rancaekek	A5	79		64		yes	yes			yes	yes	yes	81%
PKM Ibun	A5	67		71		yes	yes			yes	yes	yes	76%
PKM Kertasari	A5	78		50		yes	yes			yes	yes	yes	94%
PKM Majalaya	A5	17		53		yes	yes			yes	yes	yes	31%
PKM Pacet	A5	72		57		yes	yes			yes	yes	yes	81%
PKM Paseh	A5	17		38		yes	yes			yes	yes	yes	56%
PKM Solokan Jeruk	A5	72		71		yes	yes			yes	yes	yes	81%
CIREBON						100%	100%	yes	yes	100.0%	100.0%	100.0%	94%
RSUD Waled	A3	56	69	85	33	yes	yes	Per district	Per district	yes	yes	yes	72%
PKM Sindang Laut	A4	42		69		yes	yes			yes	yes	yes	100%

	Performance Standards												
Vanguard Network	**Assessment #**	**Maternal**	**Newborn**	**Infection Prevention**	**Governance**	**Service Charter**	**Perjanjian Kerjasama** (MOU)	**Pokja (wrk group)**	**Civic Forum**	**SijariEMAS** (referral ICT)	**Sigapku** (citizen feedback, ICT)	**SIPPP** (Learning and Performance Reinforcement)	**Referral Standards**
PKM Tersana	A4	74		63		yes	yes			yes	yes	yes	100%
PKM Sedong	A4	78		67		yes	yes			yes	yes	yes	94%
PKM Losari	A3	79		44		yes	yes			yes	yes	yes	100%
PKM Babakan	A4	74		81		yes	yes			yes	yes	yes	100%
PKM Gebang	A3	84		88		yes	yes			yes	yes	yes	94%
PKM Pangenan	A4	74		57		yes	yes			yes	yes	yes	94%
PKM Karang Sembung	A4	72		85		yes	yes			yes	yes	yes	100%
PKM Kamarang	A4	56		71		yes	yes			yes	yes	yes	94%
RB DIANA	A4	83		88		yes	yes			yes	yes	yes	82%
BANYUMAS						100%	100%	yes	yes	100.0%	100.0%	100.0%	66%
RSUD Margono	A4	100	100	83	100	yes	yes	Per District	Per District	yes	yes	yes	60%
RSUD Banyumas	A4	85	100	85	50	yes	yes			yes	yes	yes	69%
PKM Sumpiuh I	A5	100		94		yes	yes			yes	yes	yes	75%
PKM Sumpiuh II	A4	100		94		yes	yes			yes	yes	yes	75%
PKM Kemarajen II	A5	100		94		yes	yes			yes	yes	yes	69%
PKM Sukaraja I	A5	95		88		yes	yes			yes	yes	yes	69%
PKM Sumbang II	A5	100		94		yes	yes			yes	yes	yes	63%

	Performance Standards												
Vanguard Network	**Assessment #**	**Maternal**	**Newborn**	**Infection Prevention**	**Governance**	**Service Charter**	**Perjanjian Kerjasama** (MOU)	**Pokja (wrk group)**	**Civic Forum**	**SijariEMAS** (referral ICT)	**Sigapku** (citizen feedback, ICT)	**SIPPP** (Learning and Performance Reinforcement)	**Referral Standards**
PKM Batu Raden I	A5	100		94		yes	yes			yes	yes	yes	69%
PKM Kebasen	A5	100		100		yes	yes			yes	yes	yes	81%
PKM Rawalo	A5	95		94		yes	yes			yes	yes	yes	44%
PKM Jatilawang	A4	95		94		yes	yes			yes	yes	yes	63%
PKM Cilongok I	A5	100		94		yes	yes			yes	yes	yes	81%
BKIA KARTINI	A5	100		94		yes	yes			yes	yes	yes	35%
TEGAL						100%	100%	yes	yes	100.0%	100.0%	100.0%	78%
RSI PKU Muhammadiyah	A4	92	85	85	33	yes	yes	Per district	Per district	yes	yes	yes	67%
RS Adella	A4	84	91	95	17	yes	yes			yes	yes	yes	56%
RSUD Soeselo Slawi	A4	92	88	90	50	yes	yes			yes	yes	yes	61%
PKM Margasari	A2	50		not conducted		yes	yes			yes	yes	yes	88%
PKM Pagiyanten	A1	89		75		yes	yes			yes	yes	yes	88%
PKM Jatinegara	A4	94		80		yes	yes			yes	yes	yes	76%
PKM Bumijowo	A4	89		93		yes	yes			yes	yes	yes	71%
PKM Surodadi	A2	33		not conducted		yes	yes			yes	yes	yes	65%

	Performance Standards												
Vanguard Network	**Assessment #**	**Maternal**	**Newborn**	**Infection Prevention**	**Governance**	**Service Charter**	**Perjanjian Kerjasama** (MOU)	**Pokja (wrk group)**	**Civic Forum**	**SijariEMAS** (referral ICT)	**Sigapku** (citizen feedback, ICT)	**SIPPP** (Learning and Performance Reinforcement)	**Referral Standards**
PKM Pagerbarang	A1	56		not conducted		yes	yes			yes	yes	yes	82%
PKM Balapulang	A4	100		94		yes	yes			yes	yes	yes	94%
PKM Dukuh Waru	A2	6		not conducted		yes	yes			yes	yes	yes	94%
PKM Tarub	A2	33		not conducted		yes	yes			yes	yes	yes	88%
RB Mafroh Dukuh Turi	A1	6		not conducted		yes	yes			yes	yes	yes	88%
MALANG						100%	100%	yes	yes	100.0%	100.0%	100.0%	83%
RSUD Kanjuruhan Malang	A6	95	94	75	100	yes	yes	Per District	Per District	yes	yes	yes	61%
RS Bala Keselamatan Bokor	A6	71	82	85	67	yes	yes			yes	yes	yes	61%
RSI Gondanglegi (NU)	A6	92	93	75	50	yes	yes			yes	yes	yes	67%
RS Mitra Delima Bululawang	A6	97	76	90	67	yes	yes			yes	yes	yes	78%
PKM Turen	A6	84		81		yes	yes			yes	yes	yes	88%
PKM Ampel Gading	A6	95		94		yes	yes			yes	yes	yes	88%
PKM Dampit	A6	95		100		yes	yes			yes	yes	yes	94%
PKM Danomulyo	A6	84		88		yes	yes			yes	yes	yes	100%

	Performance Standards												
Vanguard Network	**Assessment #**	**Maternal**	**Newborn**	**Infection Prevention**	**Governance**	**Service Charter**	**Perjanjian Kerjasama** (MOU)	**Pokja (wrk group)**	**Civic Forum**	**SijariEMAS** (referral ICT)	**Sigapku** (citizen feedback, ICT)	**SIPPP** (Learning and Performance Reinforcement)	**Referral Standards**
PKM Sumber Pucung	A6	84		56		yes	yes			yes	yes	yes	94%
PKM Gondang Legi	A6	95		88		yes	yes			yes	yes	yes	88%
PKM Pakisaji	A6	89		93		yes	yes			yes	yes	yes	88%
PKM Pagak	A6	94		56		yes	yes			yes	yes	yes	88%
SIDOARJO						100%	100%	yes	yes	100.0%	100.0%	100.0%	73%
RSUD Sidoarjo	A6	74	94	95	67	yes	yes	Per district	Per district	yes	yes	yes	56%
RS Anwar Medika	A6	95	94	95	67	yes	yes			yes	yes	yes	61%
RS Siti Khodijah	A6	95	100	100	67	yes	yes			yes	yes	yes	78%
PKM Taman	A6	95		87		yes	yes			yes	yes	yes	82%
PKM Waru	A6	47		87		yes	yes			yes	yes	yes	65%
PKM Krian	A6	79		47		yes	yes			yes	yes	yes	82%
PKM Tarik	A6	68		80		yes	yes			yes	yes	yes	71%
PKM Sedati	A6	89		87		yes	yes			yes	yes	yes	82%
PKM Sukodono	A6	83		93		yes	yes			yes	yes	yes	88%
PKM Wonoayu	A6	89		87		yes	yes			yes	yes	yes	71%
PKM Balongbendo	A6	72		80		yes	yes			yes	yes	yes	71%

	Performance Standards												
Vanguard Network	**Assessment #**	**Maternal**	**Newborn**	**Infection Prevention**	**Governance**	**Service Charter**	**Perjanjian Kerjasama** (MOU)	**Pokja (wrk group)**	**Civic Forum**	**SijariEMAS** (referral ICT)	**Sigapku** (citizen feedback, ICT)	**SIPPP** (Learning and Performance Reinforcement)	**Referral Standards**
PINRANG						100%	100%	yes	yes	100.0%	100.0%	100.0%	85%
RSUD Lasinrang	A5	75	94	100	100	yes	yes	Per district	Per district	yes	yes	yes	83%
RS Aisyiyah St Khadijah	A5	91	91	85	33	yes	yes			yes	yes	yes	81%
PKM Tuppu	A3	67		81		yes	yes			yes	yes	yes	71%
PKM Bungin	A3	72		50		yes	yes			yes	yes	yes	88%
PKM Lampa	A4	79		93		yes	yes			yes	yes	yes	94%
PKM Tadang Palie	A3	56		73		yes	yes			yes	yes	yes	88%
PKM Suppa	A3	67		93		yes	yes			yes	yes	yes	88%
PKM Mattirobulu	A3	78		88		yes	yes			yes	yes	yes	88%
PKM Batulappa	A3	89		50		yes	yes			yes	yes	yes	76%
PKM Matambong	A4	58		81		yes	yes			yes	yes	yes	82%
PKM Larinsang	A3	72		88		yes	yes			yes	yes	yes	94%
PKM Ujung Lero	A3	67		93		yes	yes			yes	yes	yes	88%

Table 3: Hospital Clinical Assessment Results

Hospital		Maternal							Neonatal								IP	Governance		
	Assessment #	Tool 1 : Emergency Response	Tool 2 : Active III Stage	Tool 3 : Post-Partum Hemorrhage	Tool 4 : Pre-Eclampsia/Eclampsia	Tool 5 : Sepsis & Infection	Tool 6 : Obstructed Labor	% Total Maternal Standard Achieved	Tool 1 : Emergency Response	Tool 2 : Neonatal Resuscitation	Tool 3 : Neonatal Sepsis	Tool 4 : Steroid Antenatal	Tool 6 : Kangaroo Method	Tool 5 : IMD & ASI exclusive	Tool 6 : Kangaroo Method	% Total Neonatal Standard Achieved	% Total Infection Prevention achieved	Tool 1 : Clinical Performance and Evaluation	Tool 2 : Client Satisfaction	% Total Governance Achieved
RSUD Abdul Manan Simatupang	A4	20	100	83	100	100	100	87	20	67	38	67	100	83	100	62	68	75	100	80
RS Ibu Kartini	A4	67	100	17	63	67	75	65	40	67	50	67	17	83	17	53	47	0	0	0
RSUD Deli Serdang	A4	100	100	100	100	60	100	97	80	100	63	na	100	100	100	87	93	0	0	0
RS Muhammadiyah Medan	A4	80	83	50	100	50	100	79	60	100	75	67	83	67	83	76	90	25	100	40
RS Sembiring	A4	80	67	50	38	60	100	66	80	67	75	100	33	67	33	68	40	25	50	33
RS Haji	A4	80	67	50	50	83	88	69	80	83	75	67	100	67	100	79	86	0	0	0
RSUD Serang	A4	60	100	100	88	83	68	82	40	100	63	100	67	100	67	76	100	50	100	67
RSUD Majalaya	A5	80	100	83	100	100	88	92	100	100	63	100	67	100	67	85	95	50	50	50
RSUD Waled	A3	60	100	33	38	50	63	56	20	100	75	67	60	83	60	69	85	0	100	33
RSUD Margono	A4	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	83	100	100	100
RSUD Banyumas	A4	80	100	83	75	83	88	85	100	100	100	100	100	100	100	100	85	25	100	50

Hospital		Maternal							Neonatal								IP	Governance		
	Assessment #	Tool 1 : Emergency Response	Tool 2 : Active III Stage	Tool 3 : Post-Partum Hemorrhage	Tool 4 : Pre-Eclampsia/Eclampsia	Tool 5 : Sepsis & Infection	Tool 6 : Obstructed Labor	% Total Maternal Standard Achieved	Tool 1 : Emergency Response	Tool 2 : Neonatal Resuscitation	Tool 3 : Neonatal Sepsis	Tool 4 : Steroid Antenatal	Tool 6 : Kangaroo Method	Tool 5 : IMD & ASI exclusive	Tool 6 : Kangaroo Method	% Total Neonatal Standard Achieved	% Total Infection Prevention achieved	Tool 1 : Clinical Performance and Evaluation	Tool 2 : Client Satisfaction	% Total Governance Achieved
RSUD Soesilo Slawi	A4	100	100	100	100	67	88	92	80	100	63	100	100	100	100	88	90	25	100	50
RSI PKU Muhammadiayah	A4	100	100	100	88	67	100	92	80	100	50	100	100	100	100	85	85	25	50	33
RS Adela	A4	100	100	67	88	75	75	84	100	100	75	100	100	83	100	91	95	25	0	17
RSUD Kanjuruhan Malang	A6	80	100	83	100	100	100	95	80	100	88	100	100	100	100	94	75	100	100	100
RS Bala Keselamatan Bokor	A6	20	100	80	71	75	75	71	80	83	50	100	100	100	100	82	85	100	50	67
RSI Gondanglegi (NU)	A6	80	100	83	100	80	100	92	100	83	75	100	100	100	100	93	75	25	100	50
RS Mitra Delima Bululawang	A6	100	100	100	88	100	100	97	60	83	63	100	83	83	83	76	90	50	100	67
RSUD Sidoarjo	A6	80	67	67	75	67	86	74	80	100	100	100	83	100	83	94	95	50	100	67
RS Anwar Medika	A6	100	100	80	100	80	100	95	80	100	88	100	100	100	100	94	95	50	100	67
RS Siti Khodijah	A6	100	100	80	100	100	88	95	100	100	100	100	100	100	100	100	100	50	100	67
RSUD Lasinrang	A5	100	100	80	75	20	71	75	100	100	75	100	100	100	100	94	100	100	100	100
RS Aisyiyah St Khadijah	A5	100	100	60	88	100	100	91	100	100	71	100	100	83	100	91	85	0	100	33

Table 4: Puskesmas Clinical Assessment Results

PUSKESMAS	Assessment #	Tool 1 : Emergency Response	Tool 2 : Skill Assessment	Tool 3 : Emergency Referral	Tool 4 : Tools and Equipment	% of Total Puskesmas Standard Achieved	% Total Infection Prevention
ASAHAN		70	86	54	0	69	66
PKM Tinggi Raja	A3	40	86	0		44	94
PKM Rawang Pasar IV	A3	40	43	50		44	27
PKM Aek Songsongan	A4	80	100	50	0	74	67
PKM Binjai Serbangan	A3	80	100	67	0	79	13
PKM Simpang Empat	A3	80	100	83	0	84	50
PKM Pulau Rakyat	A3	80	57	50		61	88
PKM Bandar Pasir Mandoge	A4	80	100	83	0	84	88
PKM Meranti	A4	80	100	50		78	100
DELI SERDANG		74	67	57	0	64	66
PKM Bangun Purba	A3	80	100	83		89	94
PKM Tiga Juhar	A3	80	0	17		28	44
PKM Sibiru-Biru	A3	80	86	67		78	67
PKM Namorambe	A3	80	86	17	0	58	25
PKM Pantai Labu	A3	80	86	50		72	63
PKM Talun Kenas	A4	80	100	100	0	89	94

PUSKESMAS	Assessment #	Tool 1 : Emergency Response	Tool 2 : Skill Assessment	Tool 3 : Emergency Referral	Tool 4 : Tools and Equipment	% of Total Puskesmas Standard Achieved	% Total Infection Prevention
PKM Tanjung Morawa	A2	20	14	17	0	16	0
PKM Batang Kuis	A3	80	100	67	0	79	80
PKM Aras Kabu	A4	80	100	67		83	100
PKM Bandar Khalifah	A3	80	0	83	0	47	94
SERANG		68	52	76	33	66	74
PKM Kramatwatu	A3	80	86	83	0	79	94
PKM PAMARAYAN	A3	100	86	83	100	89	94
PKM Petir	A3	60	0	83	0	42	69
PKM Cikande	A2	75	86	50	0	67	40
PKM Anyer	A2	60	0	67		39	80
PKM Cikeusal	A2	40	0	83		39	21
PKM Kraglian	A3	40	43	83		56	56
PKM Ciomas	A2	80	100	100		94	88
PKM Pontang	A3	100	86	67		89	94
PKM Bojonegara	A2	80	71	50		67	100
BANDUNG		73	68	42	100	61	60
PKM Ciparay	A5	100	100	71	100	84	71
PKM Rancaekek	A5	100	100	64	100	79	64

PUSKESMAS	Assessment #	Tool 1 : Emergency Response	Tool 2 : Skill Assessment	Tool 3 : Emergency Referral	Tool 4 : Tools and Equipment	% of Total Puskesmas Standard Achieved	% Total Infection Prevention
PKM Ibun	A5	80	71	71		67	71
PKM Kertasari	A5	80	100	50		78	50
PKM Majalaya	A5	20	0	53		17	53
PKM Pacet	A5	80	100	57		72	57
PKM Paseh	A5	40	0	38		17	38
PKM Solokan Jeruk	A5	80	71	71		72	71
CIREBON		82	74	63	38	72	71
PKM Sindang Laut	A4	80	0	67	0	42	69
PKM Tersana	A4	80	71	67	100	74	63
PKM Sedong	A4	100	71	60	100	78	67
PKM Losari	A3	80	100	67	0	79	44
PKM Babakan	A4	80	71	67	100	74	81
PKM Gebang	A3	80	100	83	0	84	88
PKM Pangenan	A4	80	100	50	0	74	57
PKM Karang Sembung	A4	80	86	50		72	85
PKM Kamarang	A4	80	43	50		56	71
RB DIANA	A4	80	100	67	0	83	88

PUSKESMAS	Assessment #	Tool 1 : Emergency Response	Tool 2 : Skill Assessment	Tool 3 : Emergency Referral	Tool 4 : Tools and Equipment	% of Total Puskesmas Standard Achieved	% Total Infection Prevention
BANYUMAS		100	100	100	0	99	94
PKM Sumpiuh I	A5	100	100	100		100	94
PKM Sumpiuh II	A4	100	100	100		100	94
PKM Kemarajen II	A5	100	100	100		100	94
PKM Sukaraja I	A5	100	100	100	0	95	88
PKM Sumbang II	A5	100	100	100		100	94
PKM Batu Raden I	A5	100	100	100		100	94
PKM Kebasen	A5	100	100	100		100	100
PKM Rawalo	A5	100	100	100	0	95	94
PKM Jatilawang	A4	100	100	100	0	95	94
PKM Cilongok I	A5	100	100	100		100	94
BKIA KARTINI	A5	100	100	100		100	94
TEGAL		48	57	52	0	56	86
PKM Margasari	A2	40	67	33		50	not conducted
PKM Pagiyanten	A1	80	100	100	0	89	75
PKM Jatinegara	A4	80	86	100		94	80
PKM Bumijowo	A4	80	86	83		89	93
PKM Surodadi	A2	20	50	17		33	not conducted

PUSKESMAS	Assessment #	Tool 1 : Emergency Response	Tool 2 : Skill Assessment	Tool 3 : Emergency Referral	Tool 4 : Tools and Equipment	% of Total Puskesmas Standard Achieved	% Total Infection Prevention
PKM Pagerbarang	A1	60	60	50		56	not conducted
PKM Balapulang	A4	100	0	100		100	94
PKM Dukuh Waru	A2	0	0	17		6	not conducted
PKM Tarub	A2	0	50	17		33	not conducted
RB Mafroh Dukuh Turi	A1	20	67	0		6	not conducted
MALANG		83	100	92	33	90	82
PKM Turen	A6	80	100	83	0	84	81
PKM Ampel Gading	A6	80	100	100	100	95	94
PKM Dampit	A6	100	100	100	0	95	100
PKM Danomulyo	A6	80	100	83	0	84	88
PKM Sumber Pucung	A6	80	100	83	0	84	56
PKM Gondang Legi	A6	80	100	100	100	95	88
PKM Pakisaji	A6	80	100	83		89	93
PKM Pagak	A6	80	100	100		94	56
SIDOARJO		83	79	73	75	78	81
PKM Taman	A6	100	100	83	100	95	87
PKM Waru	A6	60	0	83	100	47	87
PKM Krian	A6	80	86	67	100	79	47

PUSKESMAS	Assessment #	Tool 1 : Emergency Response	Tool 2 : Skill Assessment	Tool 3 : Emergency Referral	Tool 4 : Tools and Equipment	% of Total Puskesmas Standard Achieved	% Total Infection Prevention
PKM Tarik	A6	80	71	67	0	68	80
PKM Sedati	A6	100	100	67		89	87
PKM Sukodono	A6	80	86	83		83	93
PKM Wonoayu	A6	80	100	83		89	87
PKM Balongbendo	A6	80	86	50		72	80
PINRANG		86	47	87	33	70	79
PKM Tuppu	A3	100	43	67		67	81
PKM Bungin	A3	80	43	100		72	50
PKM Lampa	A4	80	57	100	100	79	93
PKM Tadang Palie	A3	80	29	67		56	73
PKM Suppa	A3	100	29	83		67	93
PKM Mattirobulu	A3	80	57	100		78	88
PKM Batulappa	A3	100	86	100	0	89	50
PKM Matambong	A4	80	43	67	0	58	81
PKM Larinsang	A3	80	43	100		72	88
PKM Ujung Lero	A3	80	43	83		67	93

Table 5: Hospital Referral Assessment Results

Facility Name	1. Referral network	2. Initial preparation of emergency	3: Ambulance utilization	4: AMP	5: Public accountability	6: Quality drill service	7: Referral back	% achievement
RSUD Abdul Manan Simatupang	100%	100%	0%	100%	0%	50%	50%	61%
RS Ibu Kartini	75%	50%	50%	67%	33%	0%	50%	50%
RSUD Deli Serdang	100%	100%	50%	67%	67%	50%	50%	72%
RS Muhammadiyah Medan	100%	0%	0%	33%	33%	0%	0%	33%
RS Sembiring	100%	50%	50%	0%	0%	0%	50%	39%
RS Haji	100%	50%	50%	100%	67%	0%	0%	61%
RSUD SERANG	75%	100%	50%	100%	67%	0%	100%	72%
RSUD Majalaya	100%	100%	50%	33%	100%	100%	50%	78%
RSUD WALED	75%	100%	50%	100%	67%	0%	100%	72%
RSUD Margono	100%	50%	100%		33%	0%	50%	60%
RSUD Banyumas	100%	100%	50%	100%	33%	0%	100%	69%
RSI PKU Muhammadiyah	100%	50%	50%	67%	67%	50%	50%	67%
RS Adella	75%	50%	50%	100%	67%	0%	0%	56%
RSUD Soeselo Slawi	75%	100%	50%	67%	33%	50%	50%	61%
RSUD Kanjuruhan Malang	100%	50%	50%	33%	67%	0%	100%	61%
RS Bala Keselamatan Bokor	100%	100%	100%	33%	33%	0%	50%	61%
RSI Gondanglegi (NU)	100%	100%	100%	67%	33%	0%	50%	67%
RS Mitra Delima Bululawang	100%	100%	100%	100%	33%	0%	100%	78%
RSUD Sidoarjo	75%	100%	50%	100%	0%	0%	50%	56%
RS Anwar Medika	75%	100%	100%	100%	33%	0%	0%	61%
RS Siti Khodijah	100%	100%	100%	100%	33%	50%	50%	78%

Facility Name	1. Referral network	2. Initial preparation of emergency	3: Ambulance utilization	4: AMP	5: Public accountability	6: Quality drill service	7: Referral back	% achievement
RSUD Lasinrang	100%	100%	50%	100%	67%	50%	100%	83%
RS Aisyiyah St Khadijah	100%	100%	50%	100%	100%	0%	100%	81%

Table 6: Health Center Referral Assessment Result

Facility Name	1. Referral Network Service	2. Pre Referral Service	3. Initiation of warning sign	4. Referral Service Package	5. Referral Service Preparation	6. Referral Back and feedback	% achievement
ASAHAN	75%	63%	50%	72%	94%	68%	
PKM Tinggi Raja	67%	0%	33%	75%	100%	56%	56%
PKM Rawang Pasar IV	67%	0%	33%	50%	100%	50%	50%
PKM Aek Songsongan	100%	100%	67%	75%	100%	81%	81%
PKM Binjai Serbangan	67%	100%	67%	75%	50%	69%	69%
PKM Simpang Empat	67%	100%	67%	75%	100%	75%	75%
PKM Pulau Rakyat	100%	50%	33%	50%	100%	63%	63%
PKM Bandar Pasir Mandoge	67%	100%	67%	100%	100%	88%	88%
PKM Meranti	67%	50%	33%	75%	100%	63%	63%
DELI SERDANG	100%	45%	47%	58%	40%	40%	
PKM Bangun Purba	100%	0%	33%	50%	50%	0%	41%
PKM Tiga Juhar	100%	0%	33%	25%	50%	67%	47%
PKM Sibiru-Biru	100%	50%	67%	50%	50%	67%	65%
PKM Namorambe	100%	50%	0%	25%	0%	0%	29%
PKM Pantai Labu	100%	0%	0%	25%	0%	0%	24%
PKM Talun Kenas	100%	100%	100%	100%	50%	67%	88%
PKM Tanjung Morawa	100%	50%	33%	75%	50%	0%	53%
PKM Batang Kuis	100%	50%	33%	50%	50%	33%	53%
PKM Aras Kabu	100%	100%	100%	100%	50%	67%	88%
PKM Bandar Khalifah	100%	50%	67%	75%	50%	100%	76%
SERANG	77%	80%	90%	100%	90%	77%	
PKM Kramatwatu	33%	100%	100%	100%	100%	33%	76%

Facility Name	1. Referral Network Service	2. Pre Referral Service	3. Initiation of warning sign	4. Referral Service Package	5. Referral Service Preparation	6. Referral Back and feedback	% achievement
PKM PAMARAYAN	33%	100%	100%	100%	100%	33%	88%
PKM Petir	100%	100%	100%	100%	100%	67%	94%
PKM Cikande	33%	100%	67%	100%	100%	67%	76%
PKM Anyer	67%	50%	100%	100%	50%	100%	82%
PKM Cikeusal	100%	50%	100%	100%	50%	100%	88%
PKM Kraglian	100%	100%	100%	100%	100%	67%	94%
PKM Ciomas	100%	100%	100%	100%	100%	100%	100%
PKM Pontang	100%	50%	67%	100%	100%	100%	88%
PKM Bojonegara	100%	50%	67%	100%	100%	100%	88%
BANDUNG	77%	31%	63%	58%	38%	33%	
PKM Ciparay	67%	50%	50%	88%	50%	50%	100%
PKM Rancaekek	50%	25%	67%	63%	50%	25%	81%
PKM Ibun	100%	50%	100%	75%	25%	67%	76%
PKM Kertasari	83%	50%	67%	63%	50%	25%	94%
PKM Majalaya	100%	0%	67%	25%	25%	0%	31%
PKM Pacet	83%	25%	50%	75%	50%	25%	81%
PKM Paseh	50%	0%	50%	38%	25%	50%	56%
PKM Solokan Jeruk	83%	50%	50%	38%	25%	25%	81%
CIREBON	98%	58%	82%	80%	78%	62%	
PKM Sindang Laut	100%	75%	83%	75%	75%	100%	100%
PKM Tersana	100%	75%	67%	75%	75%	67%	100%
PKM Sedong	83%	50%	83%	100%	75%	67%	94%
PKM Losari	100%	50%	83%	75%	75%	67%	100%
PKM Babakan	100%	50%	100%	75%	75%	50%	100%

Facility Name	1. Referral Network Service	2. Pre Referral Service	3. Initiation of warning sign	4. Referral Service Package	5. Referral Service Preparation	6. Referral Back and feedback	% achievement
PKM Gebang	100%	50%	67%	75%	75%	50%	94%
PKM Pangenan	100%	25%	67%	63%	50%	50%	94%
PKM Karang Sembung	100%	75%	83%	100%	100%	50%	100%
PKM Kamarang	100%	75%	83%	88%	75%	50%	94%
RB DIANA	100%	50%	100%	75%	100%	67%	82%
BANYUMAS	67%	59%	79%	82%	55%	30%	
PKM Sumpiuh I	67%	100%	100%	100%	50%	0%	75%
PKM Sumpiuh II	100%	50%	67%	100%	100%	0%	75%
PKM Kemarajen II	67%	50%	100%	100%	50%	0%	69%
PKM Sukaraja I	67%	100%	67%	75%	50%	50%	69%
PKM Sumbang II	100%	50%	67%	75%	50%	0%	63%
PKM Batu Raden I	67%	50%	67%	75%	100%	50%	69%
PKM Kebasen	100%	50%	100%	100%	50%	50%	81%
PKM Rawalo	33%	0%	33%	75%	50%	50%	44%
PKM Jatilawang	33%	50%	100%	75%	50%	50%	63%
PKM Cilongok I	67%	100%	100%	100%	50%	50%	81%
BKIA KARTINI	33%	50%	67%	25%	0%	33%	35%
TEGAL	80%	50%	93%	95%	95%	77%	
PKM Margasari	67%	50%	100%	100%	100%	100%	88%
PKM Pagiyanten	100%	50%	100%	100%	100%	67%	88%
PKM Jatinegara	67%	50%	67%	100%	100%	67%	76%
PKM Bumijowo	67%	50%	100%	75%	100%	33%	71%
PKM Surodadi	67%	50%	67%	75%	100%	33%	65%
PKM Pagerbarang	100%	50%	100%	100%	50%	67%	82%

Facility Name	1. Referral Network Service	2. Pre Referral Service	3. Initiation of warning sign	4. Referral Service Package	5. Referral Service Preparation	6. Referral Back and feedback	% achievement
PKM Balapulang	100%	50%	100%	100%	100%	100%	94%
PKM Dukuh Waru	100%	50%	100%	100%	100%	100%	94%
PKM Tarub	67%	50%	100%	100%	100%	100%	88%
RB Mafroh Dukuh Turi	67%	50%	100%	100%	100%	100%	88%
MALANG	100%	100%	79%	100%	100%	71%	
PKM Turen	100%	100%	67%	100%	100%	67%	88%
PKM Ampel Gading	100%	100%	67%	100%	100%	67%	88%
PKM Dampit	100%	100%	100%	100%	100%	67%	94%
PKM Danomulyo	100%	100%	100%	100%	100%	100%	100%
PKM Sumber Pucung	100%	100%	100%	100%	100%	67%	94%
PKM Gondang Legi	100%	100%	67%	100%	100%	67%	88%
PKM Pakisaji	100%	100%	67%	100%	100%	67%	88%
PKM Pagak	100%	100%	67%	100%	100%	67%	88%
SIDOARJO	100%	63%	71%	100%	56%	50%	
PKM Taman	100%	100%	67%	100%	50%	67%	82%
PKM Waru	100%	0%	67%	100%	50%	33%	65%
PKM Krian	100%	100%	67%	100%	50%	67%	82%
PKM Tarik	100%	50%	67%	100%	50%	33%	71%
PKM Sedati	100%	100%	67%	100%	50%	67%	82%
PKM Sukodono	100%	50%	100%	100%	100%	67%	88%
PKM Wonoayu	100%	50%	67%	100%	50%	33%	71%
PKM Balongbendo	100%	50%	67%	100%	50%	33%	71%
PINRANG	97%	80%	97%	95%	40%	87%	
PKM Tuppu	100%	0%	100%	75%	0%	100%	71%

Facility Name	1. Referral Network Service	2. Pre Referral Service	3. Initiation of warning sign	4. Referral Service Package	5. Referral Service Preparation	6. Referral Back and feedback	% achievement
PKM Bungin	100%	100%	67%	100%	50%	100%	88%
PKM Lampa	100%	100%	100%	100%	50%	100%	94%
PKM Tadang Palie	100%	100%	100%	75%	50%	100%	88%
PKM Suppa	100%	100%	100%	100%	50%	67%	88%
PKM Mattirobulu	100%	50%	100%	100%	50%	100%	88%
PKM Batulappa	100%	50%	100%	100%	0%	67%	76%
PKM Matambong	67%	100%	100%	100%	50%	67%	82%
PKM Larinsang	100%	100%	100%	100%	50%	100%	94%
PKM Ujung Lero	100%	100%	100%	100%	50%	67%	88%

ANNEX 3: EMAS COST SHARE STATUS – YEAR TWO

#	Activity/Project	Description	Status			
			Actual		Committed	Potential
	Name of EMAS activity supported by non-USG funds OR Name of project/program that contributes to EMAS goals funding with non-USG funding	Description of the activity/project	Reported and recorded as cost share to USAID	Documentation being finalized	Funds committed, but not yet spent or recorded	Likely cost share, but not yet committed
Support to EMAS Workplan Activities						
1	Jhpiego - Direct Salary Support	Salary support for Jhpiego staff employed by EMAS	$ 56,726		$ 80,176	
2	Pfizer Fellowship Program - EMAS Communications, governance and financial support	Three Pfizer fellows provide support as follows: 1) development of a communications strategy aimed at motivating EMAS facilities to increase performance, 2) refinement of EMAS governance approaches, 3) assistance to improve LKBK financial reporting systems			$ 250,000	
3	Boston Children's/Mass General - Mentoring Support Volunteers	A group of US-based physicians providing targeted mentoring in newborn care to EMAS facilities.		$ 22,500	$ 977,500	
4	3iE - SijariEMAS evaluation	Conduct an impact evaluation of SijariEMAS				$ 250,000
5	Telkomsel - SijariEMAS Support	ICT intervention on SMS for SijariEMAS				$ 50,000

#	Activity/Project	Description	Status			
			Actual		Committed	Potential
	Name of EMAS activity supported by non-USG funds OR Name of project/program that contributes to EMAS goals funding with non-USG funding	Description of the activity/project	Reported and recorded as cost share to USAID	Documentation being finalized	Funds committed, but not yet spent or recorded	Likely cost share, but not yet committed
6	Waskita Karya - Provision of Medical equipment	Procurement of equipment for targeted EMAS facilities (e.g... scales, CPAP, tubing, etc.)				$ 45,455
7	Darya Varia - M&E Register	Printing Standardized Registers for EMAS facilities			$ 3,818	
8	Government - EMAS Launch and Socialization Activities - Year 1, Phase 1 Districts	Support to launch EMAS and socialize the program among stakeholders.		$ 6,964	$ 107,700	
9	Government - Office Space	Provision of EMAS office space, rooms and utilities		$ 7,881		
10	Government - Equipment & Vehicle	Provision of equipment, ambulance, ICT hardware & software for EMAS program		$ 1,710	$ 456,131	$ 203,127
11	Government - Facility renovations	Funds for renovation of NICU, puskesmas, meeting rooms, etc.		$ 2,186	$ 614,129	$ 183,455
12	Government - Publications & Media	Support for printing publications and media exposure funded by DHO or other partners		$ 618	$ 13,679	

#	Activity/Project	Description	Status			
			Actual		Committed	Potential
	Name of EMAS activity supported by non-USG funds OR Name of project/program that contributes to EMAS goals funding with non-USG funding	Description of the activity/project	Reported and recorded as cost share to USAID	Documentation being finalized	Funds committed, but not yet spent or recorded	Likely cost share, but not yet committed
13	Government - Supervision, Mentoring, Training, Staffing	Supervision activities are done by DHO staff where their contribute for transportation, mentoring or training by local budget			$ 4,718	$ 2,867
14	Government - Mentoring Activities	Support for K1 management, clinical assessment, internship, mentoring, P3 & P4, dashboard			$ 11,870	$ 2,618
15	Government - POKJA Activities	Support for monthly meeting costs			$ 3,049	$ 6,455
16	Government - Puskesmas Rotations	Support for rotations from Puskesmas to Hospital		$ 4,091	$ 3,436	
17	Government - Jampersal	Support for socializing Jampersal		$ 1,731		
18	Government - Citizen Report Card	Support for conducting CRC			$ 5,455	
19	Government - EMAS Assessments	Support for conducting EMAS baseline and ICT assessments		$ 1,556	$ 1,182	
20	Government - Technical Expertise	Salary costs of resource persons in EMAS workshop			$ 2,500	

#	Activity/Project	Description	Status			
			Actual		Committed	Potential
	Name of EMAS activity supported by non-USG funds OR Name of project/program that contributes to EMAS goals funding with non-USG funding	Description of the activity/project	Reported and recorded as cost share to USAID	Documentation being finalized	Funds committed, but not yet spent or recorded	Likely cost share, but not yet committed
	Sub-Total		**$ 56,726**	**$ 49,236**	**$ 2,535,344**	**$ 743,976**
Support to EMAS Program Objectives						
21	Government - SMS on MNH	Support for sending SMS messages sent directly to pregnant women about emergency maternal and newborn care		$ 1,091		
22	Government - Replication & Adoption EMAS Model	Scale up of CRC activities outside of target areas.			$ 409	$ 81,345
23	Government - Midwives Training	Support for PONED training for 10 Puskesmas			$ 31,182	
24	Rickitt Benckiser - Newborn Survival project	Health, hygiene and hand washing for newborn survival program in Bandung.	$ 113,960		$ 535,000	
25	GE Foundation - SMSbunda	SMS service targeting pregnant women in the ANC and PNC period to expand reach of EMAS to reach mothers in communities directly		$ 11,453	$ 1,988,547	

#	Activity/Project	Description	Status			
			Actual		Committed	Potential
	Name of EMAS activity supported by non-USG funds OR Name of project/program that contributes to EMAS goals funding with non-USG funding	Description of the activity/project	Reported and recorded as cost share to USAID	Documentation being finalized	Funds committed, but not yet spent or recorded	Likely cost share, but not yet committed
26	Exxon Mobile - MNH Services	Strengthen the quality of MNH services in Tuban and Bojonegoro in East Java	$ 290,795	$ 23,147		
27	Chevron - PONED Services	Improve PONED services in Riau and East Kalimantan	$ 167,347			
28	BMGF - Family Planning Services	Improving or initiating postpartum family planning services in hospitals and puskesmas in MOH priority provinces				$ 1,000,000
29	Merck - Family Planning Services	Technical updates and clinical training in family planning in Bogor, Serang, and Karawang				$ 100,000
30	International Midwives day	3-Day event to support national-level advocacy around maternal and newborn health.		$ 16,269		
	Sub-total		**$ 572,102**	**$ 51,960**	**$ 2,555,138**	**$ 1,181,345**
	Grand Total		**$ 628,829**	**$ 101,196**	**$ 5,090,482**	**$ 1,925,321**

ANNEX 4: EMAS MATERIALS, PUBLICATIONS AND MEDIA

#	Title/Description
Publications/Reports	
1	EMAS Program Brochure (Indonesian & English), April 2013.
2	EMAS ICT Factsheet (Indonesian & English), June 2013
3	EMAS Referral Factsheet (English), Draft, September 2013
4	Maternal and Newborn Health Data Factsheets (English), August 2013
5	Maternal and Newborn & Reproductive Health Infographic (English), Draft, September 2013
6	M & E Quarterly Update, September 2013.
7	District Factsheet, Deli Serdang, June 2013
Operational Guidelines & Technical Materials[3]	
8	EMAS Branding Guidelines (Indonesian & English), April 2013.
9	Pocket Book of Maternal and Child Health Motivator
10	Facilitator Training Guide: Civil Society Index (CSI)
11	Technical Guidelines: Measuring Civil Society Index (CSI)
12	Technical Facilitators Guide: Measuring Civil Society Index (CSI)
13	Technical Guidelines: Facilitating the Cooperation Agreement among Facilities (PK).
14	Technical Guidelines: Establishment and Facilitation of Working Group EMAS.
15	Technical Guidelines: Establishment and Strengthening Civil Society Forum
16	General Guidelines: Monitoring Maternal and Neonatal Emergency Services
17	General Guidelines: Implementation of Notice Facilitation Services in Health Services Maternal and Newborn.
18	Practical Guide: Clinical Governance
19	Practical Guide: Clinical Governance Mentoring
20	Practical Guide: Near Miss and Death Audit
21	Practical Guide: Dashboard
22	Facilitation Guide: Establishment of AMP
23	Practical Guide: Data entry and referral system performance monitoring tools for emergency maternal and newborn care
24	Guide: Use of emergency maternal and newborns referral system through facilitative supervision
25	Practical Guidelines: Emergency maternal and newborns referral system for Puskesmas and Hospitals

[3] As of September 30,2013, EMAS operational and technical guidelines were in final stages of layout and design.

26	Implementation Guide: SIGAPKU
27	Implementation Guide: SIJARIEMAS
28	Implementation Guide: SIPPP
Media (Social Media, Press Releases, Radio, Newspaper, TV)	
29	EMAS Facebook Account: http://www.facebook.com/EMASIndonesia
30	EMAS Twitter Account: http://www.twitter.com/EMASIndonesia
31	Media Coverage: Newborn Technical Update, February 2013 *Radio*: D FM, 103.4. (21/2) *Newspapers* (printed/ on line: Tempo.co (27/2), Viva News (27/2), Inilah.com (27/2), Kabar 24.com (27/2), Aktual.Co (27/2), Detik.com (27/2), Puskomlik (27/2), Republika (27/2), Media Indonesia (27/2).
32	Media Coverage: International Day of Midwife, May 2013 *Radio*: D FM, 103.4. (19/4) *Newspapers (printed/ on line*): Metronews.com (5/5), Antaranews.com (5/5), Repubika.co.id (3/5), Republika.co.id (5/5), Tempo.co (4/5), Liputan6.com (4/5), Mediapublica.co (4/5), The Jakarta Post (5/5), Koran Tempo (6/5), Media Indonesia (6/5), Jawa Pos (7/5), Jawa Pos (7/5) *TV:* Jak-TV (7/5)
33	Radio: Interactive dialogue at Radio Pertiwi (Public Radio of Tegal District). Talking about EMAS Program, May 2,2013
Websites	
34	EMAS Website: www.emasindonesia.org
Video	
35	International Day of the Midwife: 4 Honorable Midwives Video, May 16, 2013
36	Success Story: Saving a Life in Aras Kabu, North Sumatra, July 16, 2013 (Draft)
37	How to: SijariEMAS demonstration, September 30,2013
38	"Duta KIA" (MNCH ambassador), May 2013